Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 00501 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 20<u>10</u> $\textbf{J}_{An}^{\text{Month}}$ Physician/ 3:050M Nellie L. Winpigler Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 327 Riverside Drive Essex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** (Month, Day, Year) Days Hours Min Country) 1 □ M 2 🖵 F 220-38-5041 Director Usual Residence of Decedent 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland Director Baltimore Essex MD 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number 21221 Funeral 327 Riverside Drive USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11 Marital Status Armed Forces Black White etc. 1 Never Married 2 Married þ 1 Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 15 Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) own home Homemaker 12th Be permit. Page 1 and 2 should be filed.
Department of Health and Mental Hy Important: If item 27 is marked other any injury or other traumatic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ္ Johnie Estelle Meador Walter Lee Thompson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
-in-law 327 Riverside Drive Balto. MD 19a. Informant's Name/Relationship (Type, Print) Laura Winpigler /daughter 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Bayview Crematory 1/12/10 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Baltimore MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility 300 Mace Ave. Balto. Signature of Funeral Service Licensee ati Connelly Funeral Home of Essex 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ y orte disease or condition Medical resulting in death) Examiner Years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Hospital or Attending Physician: The law requires that the death certificate be executed to hours after death. signed by the attending physician and d be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live Birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 9 ☐ Unknown in the past 12 months?

1 Yes 2 No
9 Unknown Day Month the funeral director, page 2 should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Choon 1 X Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has performed? Yes 2 X No 1 Yes 2 No 25. Was case referred to medical examiner?
1 → Yes 2 □ No 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27, Manner of Death 28b. Time of 28c. Injury at Certificate: 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending work' To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After completed filled in by the fun 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check critifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 9b. Signature Jan 11 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Pring

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed

3515

32. Registrar's Sig

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decodent's Name (First, Middle, Last) 4: 55PM Physician/ 2010 ANUALL WilliAMS Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner P.G. 5611 Temple Hills Rd. Temple Hills 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 11-19-1932 Min. 1 □ M 2 🗹 F 579-48-7411 Director Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 ☐ No MD P.G. Temple Hills Md 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral J.S.A. 5611 Temple Hills Rd 20748 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. ò 1 Never Married 2 Married 1 Yes Maryland 21215-0036 1 ☐ Yes 2 No Specify. SpecBlack 3 ☐ Widowed 4 ☐ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Motor Veicle Medical Reviewer 12th Be unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) th and Mental h ပ Mamie <u>v. Lea</u> 1 and 2 should be the Health and Meitem 27 is mark 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Bruce L. Williams/Husband 5611 Temple Hills Rd. Temple Hills, MD 20748 Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Cheltenham, Ma Veteran Cemetery 1-21-10 ۸d. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ronald Taylor II Funeral Home 108 W. North Ave Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final ANCUSANG CANCEL Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of Examir burial-transit and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☑ No Month Dav Year 4 Pregnant a Pregnant at time of death s been signed by the should be detached 1 ☐ Yes 2 ☐ 9 ☐ Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law 1 24 hours after death. Funeral Director: After this certificate has b page 2 autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) Be ဂ္ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: iniury Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) R088852

State Registrar 2835

Smin Ausnuz #203 BANNIONE. MAIN/AUS21209

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

(Month, Day, Year)

1 4 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. **Edeltraud Wehrenerg** State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day January 8, 2010 2242 hrs **Medical Examiner** Edeltraud Wehrenberg 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death University Hospital **Baltimore** 5. Social Security Number 6. Sex If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In vrs. last birthdav) **Funeral** Foreign Germany Months Days Hours Min Director 214-78-2937 74 1 M 2 F 02/19/1935 Usual Residence of Decedent 10b Count 10c. City, Town or Location 10d. Inside City Limits Maryland Prince Georges 1 Yes 2 VNo Laure1 death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3331 Old Annapolis Road 20724 <u>United States of Americ</u> Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Drigin? (Specify Yes or No-14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? White, etc. 1 Never Married 2 Married Yes rmit. Pages 1 and 2 should be filed within 72 hours after of agreement of Pleadh and Mental Hygiene.
portrant: If item 27 is marked other than "natural", o portrant: If item 27 is marked other than "natural", o iury or other traumatic event, the Medical Examiner in White 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2XX No specify: Specify: <u>م</u> 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b, Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) **Baltimore, MD 21215-0036** 12 Home Maker Own Home 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Unknown Berta Feurstein 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) (Spouse) William G. Wehrenberg 3331 Old Annapolis Rd, Laurel, Maryland 20724 20b. Place of Disposition (Name of cemetery, 20a Method of Disposition 20c. Location - City or Town, State crematory or other place) 1 Burial 2 XXCremation 3 Removal from State Atlantic Crematory 01/12/10 Glen Burnie, MD 21061 4 Donation 5 Other Specify. 21. Signature of Furieral Service Licensee 22. Name and Address of Facility Fleck Funeral Home 7601 Sandy Spring Road, Laurel, Maryland 20707 MUSERY Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Approximate Interval Between Onset and **IMedica** Death Complications of blunt force head trauma Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last attending physician and or use as the burial - trans Physician/Medical X UNPENDED ,23a,27,28a-f,permE, g900 2/26/10 TT Box 68760. IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Month Year Fetal death Dav past 12 months? Pregnant at time of Other (Specify) 1 Yes 2 V No 9 Unknown Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 V No 3 Probably 4 Unknown Completed been 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has performed death? page 1 ✓ Yes 2 No 2 No 1 🗸 Yes the Hospital or Attending Physician: 26 Place of Death (Check only one) Division of Vital director, 25. Was case referred to medical Be Hospital; 1 🗸 Inpatient 2 Other Nursing Home 5 Residence 6 Other ER/Outpatient 3 DOA After this ۵ 1 V Yes 2 No 28d Describe how injury occurred passenger motor vehicle 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? Certification: Natural death. 1 Yes 2 X No 5 Pending the Director Fd 1/7/10 Fd 1500 hrs ick-up truck collision 2 X Accident Investigation þ 28f. Location (Street and Number or Rural Route Number, City or Town, State) Washington Blvd & 1-195 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Suicide Could not be within 24 hours at To the Funeral D (Specify) other determined Baltimore, 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ca 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number O.C.M.E. January 9, 2010 30. Name and address of person who completed cause of death (Item 23a) Russéll Alexander MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 32. Registrar's Signature State

Registrar

DHMH 17 Rev 1/2001

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at any Injury.	b	1 ☐ Never Married 2 🙀 Mar 3 ☐ Widowed 4 ☐ Divorced	ried 1 ∐ Yes 24. If Yes, Give	No		I□Yes 2XINo			Specify: White					
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s 1 ar f Hea f Hea ftem		20a. Method of Disposition		20b. Pla	ce of Dispo	sition (Name of natory or other place	; -	Date	20c. L	ocation - City or T	own, State			
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State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month 0540 M Elizabeth Beard June 01 Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** WMHS-Regional Med. umberland Center allegan 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛛 F Days Hours Oct. 29.1928 Director 236-48-3223 81 Piedmont, WV Usual Residence of Decedent shov 10a. State 10c. City, Town or Location notified at 10d. Inside City Limits Director 28a-f 1 🔀 Yes 2 🗌 No WV Mineral Keyser 10e. Street and Number 10f. Zip Code ortant: If item 27 is marked other than "natural", or items 23a or injury or other traumatic event, the Medical Examiner must be n 10g. Citizen of What Country? Funeral 1460 Beacon Street 26726 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 X No
If Yes, Give Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Whi<u>te</u> 3 - Widowed 4 - Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 h h and Mental Hygiene. 7 is marked other than "n Elementary/Seconday (0-12) College (1-4 or 5+) Registered Nurse Hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 James R. Chapman Emily Armeada Evans 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Harry Ray Beard/ Husband 1460 Beacon Street Keyser, WV 26726 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 M Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Jan. 2010 4 Donation 5 Other (Specify) Memorial Gardens 21. Signature of Foneral Service Licensee 22. Name and Address of Facility Smith Funeral Home Dulan 85 S. Main Street Keyser, WV 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Ph sician/ disease or condition resulting in death) 0 Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami attending physician and for use as the burial-transit Cause (Disease or imjur) that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be very hours after death.

Funeral Director: After this certificate has been signed by the attending physicis Records, P.O. Box 68760 yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 \(\subseteq \text{ Yes} \) 2 \(\subsete \text{ No} \) Pregnant at time of death 5 Other (specify) Month Dav Year 9 🗆 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🔲 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed 1 ☐ Yes 2 ☑ No 25. Was case referred to medical examiner? Division of Vital Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗹 No 1 🗌 Yes မ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Mann of Death Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completed filled in by the fu 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) SUDHEER JANKOMN 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sudheer Sanikommu, 12501 Willowbrook Road Cumberland, MD M.D. 21502 31. Date filed (Month, Day, Year,

Registrar DHMH 17 Rev 7/2009

State

JAN 1 1 2010

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 _ State	State of Ma	ryland	-	rtmen			and Me	ental Hy	,	2011)	00507
			Registrar 1. Decedent's Name (First, Middle, Last)				uncau	e OI L	Jeain		2. Date of D	Reg. Not	2010	J 	3. Time of Death
	Physici			MPTON, J	TR					_	Month	Day	Yea	ır	7:06 PM
-	/Medic Examir		4a. Facility Name (If not institution, give stre				4b. City,	Town, or	Location of	-	mm		County of D	eath	1.00
-7			LIONS MANOR NURSI	NG HOME			CUMI	BERL.	AND			I	ALLEGA	YV	
	Funeral Director		5. Social Security Number 6. Sex N N N	7. Age 2□ F 90	(În yrs. las	st birthday) Yrs.	If Under 1 Year If Under 24 Hrs. 8. Date of (Month) Months Days Hours Min. Mar					of Birth 9. Birthplace (State or Country) 28, 1919 ARIZONIA			v)
	70		Usual Residence of Decedent							1.		0, 13			0.1,2.1
	arylar show	<u>_</u>	10a. State 10b. County			Town or Loc								10	d. Inside City Limits 1 □ Yes 2 No
	he M	Director	MD ALLEGANY 10e. Street and Number		MT.	. SAVA		0-1				10 0'''	zen of What		77
	With Baor	ä	12900 MT. SAVAGE F	D. NW			10f. Zip	2154:	5			rog. Citi.	U. S.		y ?
	death ms 2:	Funeral		Was Decedent E	ver in U.S.	13. V	Vas Deced	ent of Hi	spanic Ori	igin? (Spec	ify Yes or N	0-	14. Race - A		n Indian,
36	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. If the Strib and Mental Hygiene. Other T is marked other than "natural", or items 23a or 28a-f show other traumatic event, Ins. Modical Exercitation and be notified at	y Fu	1 Never Married 2 Married	Armed Forces? 1 ☐Yes 2 ☐ No If Yes, Give	wwI]		Yes, spec □Yes 2		n, Mexicar Specify:	n, Puerto Ri	ican, etc.)		Black, W Specify:	nite, et VHT	
21215-0036	hours tural"	ed by	3 ₩idowed 4 Divorced	Year or Dates:		L 16a. Deced						I teh Kii			
5	iin 72 ii "na Vedic	plet	15. Decedent's Educat (Specify only highest grade of Elementary/Secondary (0-12)	ompleted)		(Give I	kind of wor OO NOT us	k done d	uring mos	t of working	7	100. KII	nd of Busine	ss/mai	istry
7	d with	Completed	12	College (1-4or 5+	,	PLUM	1BER					PI	UMBIN	G	
Maryland	be filk tral Hy d oth eveni	Be	17. Father's Name (First, Middle, Last)							,	First, Middle		Surname)		
<u> </u>	should be f and Mental s marked o sumatic eve	은	FRANK FAY COMPTON 19a. Informant's Name/Relationship (Type.			406 Mailin	_ ^	(044			CUR				2 4 3
⊠ ⊠	od 2 sho alth and 27 is ma r traum	3	TAMMY ROUNDS	NIECE							NOUTE NUMBER		Town, State 2153 .	_	Joae)
ē,	s 1 and 2 of Health item 27 i		20a. Method of Disposition		20b. Plac	ce of Dispos				Dat			cation - City	or Tow	n, State
altimore,	Pages nent of I ant: If ite ury or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ Rem 4 ☐ Donation 5 ☐ Other (Specify)	oval from State		rlawn	-			AN 9	2010	LAV	ALE,	DM	
Balt	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		21. Signature of Funeral Service Licensee	a Ron S	7		Name and			HAL			SERV	ICE 502	, P.A.
			23a. Part 1. Enter the disease or complicat	ions that caused t	he death.						LAVA respiratory		11) 21.		Approximate
L P	hysician	8 1	shock or heart failure. List only one of Immediate Cause (Final disease or condition	_	man	n A	nder	Or	fer	0					nterval Between Onset and Death
	/Medical		resulting in death)	Due to (or as a		_	1							1	- pries
	xaminer	<u></u>	Sequentially list conditions, b. –	D											
7	nsit	Examiner	Cause (Disease or injury	Due to (or as a	consellier	nce of								Ì	
60,	cate be executed oblysician and the burial-transit		that initiated events c resulting in death) Last	Due to (or as a	consequer	nce of):								+-	
876	physicie	dical	d												
39 ×	ding pl	Med	IF FEMALE;											I	
Вох	rive raw requires trial title death cerring tate has been signed by the attending E sage 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	If yes, outcome of	Fetal de	eath 3 🗆	Ectopic pr	egnancy				2	23d. Date of of Month		y Day Year
0	requires that the de been signed by the should be detached	ysic	1 □Yes 2 □No 9 □ Unknown	4 ☐ Pregnant at t 9 ☐ Unknown	ime or gea	un 5∟	Other (spe	ecity)							•
o	ned b ned b	by Pr	Part II. Other significant conditions contrib					and the same	n in Part I.	,	23e. Did	tobacco u	se contribute	to the	cause of death?
ğ	equire en sig ould bi	ed b	chin of the	worder or	Azz	ident		Di	التسمير	t wh	1 🗆	Yes 2] No 3 ☐	Proba	bly 4 thown
Records,	aw re las be	Completed	chim oldh tim	tive Pr	Am	Lun	Ris	Erzo			24a. Was		24b. Were	autop:	sy findings available pletion of cause of
		Con	In portension			/						ormed?	death	?	No
Vital	th. : After this certifics funeral director, p	Be	25. Was case referred to medical examiner?	sital				Louis			Check only	one)	-	4	
	rthis ral dir	P.	1 Yes 2 No Hos	1 ☐ Inpatien 28a. Date of Injury		NOutpatient		A Otne Bc. Injury	r: 4 Nu				Other (S	oecify)	
Division of	Attending Filysicians of death. ector: After this certific by the funeral director,	tion	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day,		Injury	M Z	Work'	?ຶ່ ′es 2. □l		d. Describe	riow injury	occurred		
NISI VISI	ector by the	Certification:	2 Suiside 6 Could not be	8e. Place of Injury	y - At home	e, farm, stre	et, factory,							Rural	Route Number,
בֿ בֿ	rs affe	Cert	4 D Hollistae	building, etc.	(Зреспу)					l/	City or 10	wn, State)			
Tool of	within 24 hours after death. To the Funeral Director: After completely filled in by the fun	Medical	29a. Certifier (Check only one) 1 Certifying Physici 2 Medical Examiner	an: To the best of On the basis of e and manner state	examination	edge, death n and/or inv	occurred a estigation,	at the tim in my op	ne, date an pinion, dea	nd place, ar ath occurred	nd due to the d at the time	e cause(s) , date and	and manner place, and c	as sta ue to f	ated. the cause(s)
÷	Withi Comp	ž	29b. Signature and title of certifier				29c.	License	number				e signed (Mo		
			1 13)					Di	2124	9		20	un ua	54	8,2010
	2+1		30. Name and address of person who comp	eted cause of dea	ath (Item 23	3a) (Type, P	rint)	Fr	ost	har	a M	10	215	フスス	2
	Sta		31. Date filed (Month, Day, Year)	32. Registrar	's Signature	Sade	0			4	0		- Lind	-	
	Registra	ar	THE SECUL	A BRANCH S	to H										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Physician/ Month Day MARY GERTRUDE CASEY 3:10A ANUARY Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK Social Security Number 7. Age (In yrs. last birthday, 82 yrs. If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 💢 F Months Hours Min. Oct. 29 306-22-2854 Director "1927 Indiana Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Examiner must be notified at Director Maryland Frederick Adamstown 1 Yes 2 No o 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 23a Funeral 21710 3200 Baker Circle items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes XX No Black. White, etc 0 Completed by 1 Never Married 2 Married 1 Yes Baltimore, Maryland 21215-0036 Specify: White 1 Yes XX No Specify: "natural", ₩XWidowed 4 □ Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Seconday (0-12) 12 College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Surname)
 Helen Meyers Fred Strack 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Jown, State, Zip Code 2416 Doubs Court, Adamstown, Mary Land 21710 Kathleen C. Secoges, daughter Department of Healt Important: If item 2 any injury or other 20a, Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Gate of Heaven Cemetery Jan. 13, 1XXBurial 2 Cremation 3 Removal from State Silver Spring, M 2010 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign e of Lineral Service Li 22. ReeneydrangaBasford PA Funeral Home M00255 21701 106 East Church St., Frederick, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each li nterval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) tdVance Medical Due to (or as a consequence of) Examiner Sequentially list conditions. in any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami or Attending Physician; The law requires that the death certificate be executed the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of). the attending physician hed for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Other (specify) Month Day Year 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 2 No No 1 🗌 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director, After this certific completed filled in by the funeral director, 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ ER/Outpatient 3 DOA 1 Inpatient 2 Certificate: Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work? 5 Pending 2 🗆 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause 29a. Certifier edical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

printing Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title 29d. Date signed (Month, Day, Year) D006 -/0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ghulam Abbas, M.D., 400 West Seventh Street, Frederick, MD 21701 17

DHMH 17 Rev 7/2009

State Registrar 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 00509 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January 5^{Day} 2010^{ear} Ruth Estelle Clubb 2:10A. Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital Takoma Park Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth Aparth, 22, 1923 **Funeral** Birthplace (State or Foreign Hours 1 □ M 2 🔀 F 577-24-0990 Director Mary Land Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Prince George's Beltsville 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11401 Rosedale Lane 20705 United States death \ 12. Was Decedent Ever in U.S. 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married within 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify 3 Widowed 4 Divorced White Specify 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. Homemaker own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 Margaret Rohrback Clarence Gasch 19a. Informant's Name/Relationship (Type, Print)
Carole L. Ward -daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code). 11401 Rosedale Lane Beltsville, Maryland 20705 permit. Page 1 and 2 st Department of Health a Important: If item 27 is 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State è 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) Metropolitan Crematory 1/6/2010 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, Virginia Signature of Funeral Service Licenses Bonald V: Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ Onset and Death disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence only Exami Cause (Disease or linjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran and Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as 1 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Dav Pregnant at time of death Year been signed by the s should be detached Unknown 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has page 2 autopsy performed? Yes 2 No 2 No 1 🗌 Yes Be (funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Certificate: To 1 🗌 Yes 2 🗹 No Other: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work?
1 Yes 2 No 5 Pending To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A Accident Investigation Could not be completed filled in by the 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 38 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Padma Chirumamilla, M.D. 7600 Carroll Avenue Takoma Park, Maryland 20912

Registrar

State

31. Date filed (Month, Day, Year,

MAN I 3 2010

32. Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Trem 26State of Maryland / Department of Health and Mental Hygiene

			State Registrar WCHD/SH 1				rtificate of l		Re	eg. No. 201	0 00510		
Ph	ysicia	ın	1. Decedent's Name (First, Middle,	_{Last)} r Ishmael C	AMPHER				2. Date of Deat Month	Day Year	3. Time of Death 9:48 PM		
	Medic camin		4a. Facility Name (If not institution,				4b. City, Town, or	Location of Death	January	4c. County of De			
, , ,	Cattill	ÇI	612 George Stre				Hagers	stown		Washing	ton		
	neral ector		220-16-0567	. Sex 7. Ago 1 ☑ M 2 ☐ F	e (In yrs. last bi 84	rthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Feb. 4,	Year) 9. B 1925 Man	irthplace (State or Foreign Country) ryland		
and			Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	n or Lo	cation				10d. Inside City Limits		
Mary	ped a	tor	Maryland Washin	gton	Hagers	tow	'n				12/C2N/es 2 □ No		
h with the	st be not	al Director	10e. Street and Number 39 Charles Stre	eet			10f. Zip Code 21740	0	1	10g. Citizen of What Country? U.S.A.			
Q Z IZ IS-UU36 filed within 72 hours after death with the Maryland Hyglene. ther than "natural" or items 23a or 28a-f show	matic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent I Armed Forces? 1 120 Yes 2 1 If Yes, Give Year or Dates:		i	Was Decedent of H If Yes, specify Cuba 1 □ Yes 2 🖾 No	ispanic Origin? (Sp in, Mexican, Puerto Specity:	pecify Yes or No- pecify Yes or No- pecify Yes	14. Race - An Black, Wh Specify:	nerican Indian, ite, etc. Black		
21215-0036 d within 72 hours aff giene.	dical	Completed	15. Decedent's (Specify only highest)	Education grade completed)		. Dece	dent's Usual Occupa	ation during most of work	king	16b. Kind of Busines	s/Industry		
Vithin vithin sine.	M Ma	du	Elementary/Secondary (0-12)	College (1-4or 5	+)		kind of work done of DO NOT use retired)	9	city gove	rnment		
G K filed v Hygic	ent, tr	ပို	17. Father's Name (First, Middle, La				Journer	18. Mother's Nam					
led be dental	tic eve	To Be	Walter	Camphe	er				Cather	rine Jon	es		
Ma Inthau	r trauma		19a. Informant's Name/Relationship Carolyn Lewis -	* * * * * * * * * * * * * * * * * * * *						, City or Town, State Maryland			
Saltimore, permit. Pages 1 an Department of Heal	ry or othe		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe				osition (Name of matory or other place 1 Cemeter	Janu	arv 6.	20c. Location - City o	or Town, State		
Saltimo permit. Page Department of	any Inju once.		21. Signature of Funeral Service Lic		Rose	22	2. Name and Addres	ss of Facility M	innich F	uneral Hor	A STATE OF THE STA		
Physic /Med Exam	lical		23a. Part 1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	ly one cause on each lir	ie.	: ,	er the mode of dyin	-			Approximate Interval Between Onset and Death WWKN WOT		
certificate be executed oding physician and	s the burial-transit	<u>ш</u>	Sequentially list conditions, if any, leading to think-clate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	a consequence								
± 5	, \alpha	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetal déatl		☐ Ectopic pregnancy ☐ Other (specify)	4		23d. Date of d Month	lelivery Day Year		
Hecords, F.O. he law requires that the e has been signed by the	ld be deta	কু	Part II. Other significant conditions	s contributing to death bu	_	n the ur	nderlying cause give	en in Part I.			to the cause of death? Probably 4 Unknown		
w req	nous	lete	HUPERT	EN SIO	n ·				24a. Was a	24b. Were	autopsy findings available		
VITAL DE Ician: The la certificate has	or, page 2	Completed	SECIEN ER. 25. Was case referred to medical			1	SEAS		autops perform 1 □ Yes 2	y prior to death? 2 No 1 □ Ye	o completion of cause of		
Attending Physician: r death. ector: After this certific	eral dire	고 B	examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident investigat	28a. Date of Inju (Month, Day	nt 2 ER/O ry 28b.	utpatier Time of Injury	f 28c. Injury Work	er: 4 Nursing Ho			HOME		
DIVISION tal or Attending s after death. al Director: Afte	ed in by th	Certification:	3 Suicide 6 Could not determine	28e. Place of Injubuilding, etc	ry - At home, fa :. (Specify)	ırm, str	eet, factory, office		28f. Location (St. City or Town	reet and Number or i n, State)	Rural Route Number,		
DIVISION To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Aft	pletely fill	edical	one)	Physician: To the best of aminer: On the basis of and manner sta	of my knowledg examination a ted.	e, deatl nd/or in	h occurred at the tin vestigation, in my o	ne, date and place pinion, death occu	, and due to the c rred at the time, d	ause(s) and manner ate and place, and d	as stated. ue to the cause(s)		
To the	СОШ	Σ	29b. Signature and title of certifier	0	40 X		29c. License			9d. Date signed (Mo			
			1 helbe	K	1110.		005	78181	J	ANUARY	4 2010		
3H 5-	+1		30. Name and address of person wh								21740		
	Stat		31. Date filed (Month, Day, Year)		ır's Signature		311 4	3.6 11/7	700-1-0				
Re	aistra	r	LAMAS	2010		100	100						

10-00018 Alisha Deneen Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Sha Beneen		1- For State Certificate Registrar Certificate		ientai riygie	Reg. N	2010	0051
Physici		Decedent's Name (First, Middle, Last)		Mo	te of Death	/ Year	3. Time of Death
edical Exami	iner	TITTOTIC TICE DETICET	T. 03 T	Jar	uary 1, 20	10	1740 hrs
		Facility Name (if not institution, give street and number) I-81 south of Exit 9	4b. City, Town, or Loca Hagerstown	ation of Death	ľ	4c. County of Death Washington	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthdate 1	"	Under 24Hrs. 8. D tours Min. Se	ate of Birth(MI	M/DD/YYYY) 9. Birti 1978 Foreign	hplace (State or n Mary Land Intry)
Å		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	coation	1			10d. Inside City Limits
ow any		Maryland Washington County Hagersto					1 Yes 2 X No
Aaryland 28a-f show 1 at once.	ctor	10e. Street and Number	10f. Zip Code		10g. C	itizen of What Coun	try?
, MD 21215-0036 eath 2 should be filed within 72 hours after death with the Maryland eath 2 should be filed within 72 hours after death with the Maryland tem 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at once.	al Director	18751 Diller Dr.	21742	0		.S.A.	and Ladina Diagram
ath wi	Funeral	1 X Never Married 2 Married Armed Forces?	Was Decedent of Hispanio If Yes, specify Cuban, Me			14. Race - Americ White, etc.	an Indian, Black,
ifter de Il", or		3 Widowed 4 Divorced If Yes, Give Year or Dates:	Yes 2X No spe	ecify:		Specify: Whit	e
nours a	ed by	15. Decedent's Education (Specify only highest grade completed) 16a. Dec	edent's Usual Occupation (on most of working life, DO		ne 16b	. Kind of Business/Ir	ndustry
21215-0036 ould be filed within 72 h 1 Mental Hygiene. s marked other than "r ic event, the Medical E	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) Teac	•	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	S	chool	
5-0 iled w Hygie d othe		17. Father's Name (First, Middle, Last)		other's Name (First,		·	
2121 ould be fi Mental I marked ic event,	To Be	Harry Deneen, Jr. 19a Informant's Name/Relationship (Type, Print) 19b. M.	ailing Address (Street and	haron Hul			Zip Code)
MD 2 d 2 shoulth and 1 is 27 is aumatic			Harvard Rd.			-	,
s l and of Healt			sposition (Name of cemeter or other place)	ry, Date	200	. Location - City or	Fown, State
Pages nent of ant; I		4 Donation 5 Other Specify: Smithsb	ourg Cremator	y 1-6-20		mithsburg	, Maryland
Baltimore, permit. Pages I and Department of Heal Important: If iten injury or other tra			22. Name and Address of F				
Physician	/	23. Part I. Enter the disease, of complications that caused the death. Do not en	1331 Eastern	BLVQ . NO	rth Ha	gerstown, hock, or heart	MD Z1/4Z Approximate Interval
/Medical		failure. List only one cause on each line. Immediate Cause (Final disease a Multiple Injuries					Between Onset and Death
Examiner		or condition resulting in death) Due to (or as a consequence of):					
	7	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):					
	Examine	cause. Enter Underlying Cause	171				
ited d ansit		events resulting in death) Last Due to (or as a consequence of): d.					
' 60, cate be executed physician and ne burial - transit	Medical	UNPENDED AMENDED					
760, cate be physic the bur	/Mec	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the			2	3d. Date of delivery	
Box 687(death certifica the attending pl	Physician/	past 12 months? 1 Live birth 2	Fetal death 3 Ed Other (Specify)	ctopic pregnancy		Month D	ay Year
BO) e death the att	hysi	1 Yes 2 No 9 V Unknown 9 Unknown					
Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death. The this certificate has been signed by the attending physician and upletely filled in by the funeral director, page 2 should be detached for use as the burial - trans	by P	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given	in Part I. 2		o use contribute to to	
ords, w require is been sig should be	Completed	-		2	4a. Was an		opsy findings available
of Vital Records, ag Physician: The law requir offer this certificate has been si neral director, page 2 should t	dm				autopsy performed¹ ✓ Yes 2	death?	ompletion of cause of
tal Recieians The certificate		25. Was case referred to medical	26.Place of De	eath (Check only on		No 1 ✓ Yes	2 110
Vita hysicia this ce	To Be	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpa	tient 3 DOA Othe	^r 4 Nursing Hom	e 5 Resid	dence 6 🗸 Other:	Scene
n of ling Pl After funera		27. Manner of Death 28a. Date of Injury 28b. Time 1 Natural 5 Pageiga FOUND Day, Year) FOUND		Drive	escribe how in r of auto to	njury occurred fixed object co	llision
Division tal or Attendir as after death. al Director: A led in by the fu	catic	Pending Investigation 2 Accident Investigation 28e Place of Injury - At home, farm,	s l'ores	2 No	postion /Street	and Number or Pur	al Route Number, City
Divis	Certification:	3 Suicide 6 Could not be determined (Specify) Interstate/Express	street, ractory, office building	or	Town, State)	9, Hagerstown, M	
Division To the Hospital or Attence within 24 hours after death To the Funeral Director:		29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death of Check only 1	occurred at the time, date ar				
To the within To the comple	Medical	one) 2 Medical Examiner: On the basis of examination and/or investant and manner stated.					
	Σ	29b. Signature and title of certifier	29c. License nun			Date signed (Mon	th, Day, Year)
		Yamely Justhall, MD	O.C.M.E.		Ja	nuary 2, 2010	
4-5		30. Name and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner	111 Penn Street, Ba	altimore, MD 21	201		
	ate	31. Date filed (Month, PartYey) 5 2010 32. Registrar's Signature	A. a.t.				
Reais							

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 00512 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ HILDA VIOLA DOVE 2010 JANUARY Medical 4a. Facilify Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK . Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days 1 🗆 M 2 🛣 F Hours 81 Director 212-24-7206 Usual Residence of Decedent 10c. City, Town or Location 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10d. Inside City Limits Director be notified 1 X Yes 2 No Frederick Frederick MD 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 23a 2477 Five Shillings Road 21701 **USA** 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian the Medical Examiner Armed Forces?
1 Yes 2 No Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give 3 ₺ Widowed 4 □ Divorced White Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Assembly AirPax Industries Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F Grover Cornelius Tobery Mabel Luella Sier other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a 2477 Five Shillings Road Frederick, MD 21701 Mary V. Dove Daughter Department of Healt Important: If Item 2 any injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Resthaven Mem. Grdn. 1-14-2010 Frederick, Maryland 4 Donation 5 Other (Speg 21. Signature of Fune al Service Lic 22. Name and Address of Facility Keeney & Basford P.A. F.H. M01176 106 East Church Street Frederick, MD 21701 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ock, or heart failure. List only one cause on each Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Litter Underlying Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Be Completed by Physician/Medical Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death Yes 2 No g Unknown g Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ruamven 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed? Yes 2 No 1 🗌 Yes 2 🗌 No 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 XNo Other: 1 Inpatient 2 ER/Outpatient 3 DOA 욛 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigat 3 🔲 Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 1 🗶 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Exampler: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Marse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of cert 29d. Date signed (Month, Day, Year) 200624 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

JAN 14 2010

32. Registrar's Signature

Ghulam Abbas MD 400 West Seventh Street Frederick, Maryland 21701

		epartment of Health and Mental H Certificate of Death	Hygiene 20 0 05 3
Physician /Medical	1. Decedent's Name (First, Middle, Last) Thomas L DAME, JR.	2. Date of Month Janua	ary 3, 2010 12:51 a.M
Examiner Funeral	4a. Facility Name (If not institution, give street and number) 10110 Mildred Drive 5. Social Security Number 6. Sex 7. Age (In yrs. last birtho	4b. City, Town, or Location of Death Hagerstown If Under 1 Year If Under 24 Hrs. 8. Date of	4c. County of Death Washington Birth 9. Birthplace (State or Foreign
Director	406-52-7661 1 ☑ M 2 □ F 70 Yrs Usual Residence of Decedent		Day, Year) Country) Kentucky
vith the Marylan or 28a-f show ce netified at Director	10a. State 10b. County 10c. City, Town of Hagers 10e. Street and Number		10d. Inside City Limits 1 ☐ Yes 2☐ No 10g. Citizen of What Country?
fter death with ritems 23a or in er oust bu	10110 Mildred Drive	21740	U.S.A.
72 hours after death with the Maryland naturals, or items 23a or 28a-f show dical Examiner must be notified at etect by Funeral Director	1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Married Forces? 1 Marr	13. Was Decedent of Hispanic Origin? (Specify Yes or If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Yes 2 ⋈ No Specify:	Black, White, etc. Specify: White
d 2 should be filed within 72 hours after death with the Maryla fit and Mental Hygiene. It samerked other than "natural" or items 23a or 28a-f show traumatic event, the Medical Examiner must be rediffied at To Be Completed by Funeral Director	(Specify only highest grade completed) (C	ecedent's Usual Occupation Site kind of work done during most of working fie. DO NOT use retired) PETVISOT	16b. Kind of Business/Industry manufacturing
wild be filed Mental Hygi arked other artic event, I	17. Father's Name (First, Middle, Last) Thomas L Dame, Sr.	18. Mother's Name (First, Mid	
and 2 should leatth and Mer m 27 is marke her traumatic.	Janet M. Dame - wife 101	Mailing Address (Street and Number or Rural Route Nu 10 Mildred Drive, Hagers	town, Maryland 21740
permit. Pages 1 and 2 s Department of Health an Important: If item 27 is any injury or other trau	4 Donation 5 Other (Specify)	isposition (Name of crematory or other place) ill Cemetery January 7, 2010	20c. Location - City or Town, State Hagerstown, Maryland
perm Depa Impo any ii	21. Signature of Funeral Service Licensee **Third Livential** 23a. Part1. Enter the disease, or complications that caused the death. Do not	415 East Wilson Blvd., Ha	
Physician /Medical Examiner	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Obstructive lun	Interval Between
ficate be executed in physician and street transit edical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last c. Due to (or as a consequence of):		
The law requires that the death certificate has been signed by the attending page 2 should be detached for use as tompleted by Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	23d. Date of delivery Month Day Year
law requires that as been signed to 2 should be deta	Part II. Other significant conditions contributing to death but not resulting in the	ne underlying cause given in Part I. 23e. D	old tobacco use contribute to the cause of death?
	25. Was case referred to medical		utopsy prior to completion of cause of death? es 2 No 1 □ Yes 2 □ No
ing Phys After this Lineral dir	examiner? 1 Yes 2 No	ne of 28c. Injury at 28d. Descri	lesidence 6 □Other (Specify) be how injury occurred
To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After completely filled in by the funeral Medical Certification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm building, etc. (Specify)		on (Street and Number or Rural Route Number, Town, State)
o the Hospital ithin 24 hours of the Funeral I on the Funeral I ompletely filled	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, dependence on the desired of the desired o	death occurred at the time, date and place, and due to or investigation, in my opinion, death occurred at the tir	the cause(s) and manner as stated. me, date and place, and due to the cause(s)
To with to	29b. Signature and title of certifier May & May & Mony	29c, License number D 238/5	29d. Date signed (Month, Day, Year)
8+ 1VA	30. Name and address of person who completed cause of death (Item 23a) (Ty Wary E. Woney, M.D.,	29c. License number D 23815 pe, Print) Will54. Ha	gerstown, MD
State Registrar	31. Date filed (Month, Day, Year) JAN 2 2010 32 Registrar's Signature	parla	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

			For State Registrar	oraro or mary	C	ertificate of	Death	mornar rry	Reg. No. 2	110	00514
ı	Physici		1. Decedent's Name (First, Middle, La Helen Anna					2. Date of De Month		20 ^Y 1ab	3. Time of Death 9:40 A M
	/Medio Examir		4a. Facility Name (If not institution, give	e street and number)	e	4b. City, Town, or	r Location of Dear		4c. Coun	ty of Death	
	Funeral Director		5. Social Security Number 6. S	Sex 7. Age (Ir	yrs. last birthd.	Monthe Dave	If Under 24 Hrs Hours Min.		3, 1915	Count	lace (State or Foreign try) ECTiCUT
	Maryland a-f show	ctor	Usual Residence of Decedent 10a. State 10b. County MD Caroli		c. City, Town or		ston				0d. Inside City Limits 1 ☐ Yes 2 【X.No
	th with the 23a or 28 ist be not	Funeral Director	10e. Street and Number 3439 Gallagher	Road		10f. Zip Code	655		10g. Citizen of Unite		•
9800	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, if w. M.dicel Eyn: if ar roust be notified at once.	by	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever Armed Forces? 1	in U.S.	3. Was Decedent of H If Yes, specify Cuba 1 □ Yes 2 ☑ No		Specify Yes or No to Rican, etc.)	- 14. Ra Bl Spec	ace - America ack, White, e ify: W	
Baltimore, Maryland 21215-0036	within 72 ho iene. than "natu in Modicel	Completed	15. Decedent's Er (Specify only highest gra Elementary/Secondary (0-12) 11 (Grad.)	ducation ide completed) College (1-4or 5+)	(G lif	icedent's Usual Occup ive kind of work done of e. DO NOT use retired igner/Arr	during most of wo d)	rking	16b. Kind of I		_{lustry} Flowers
land 2	uld be filed Mental Hyg irked other itic event, t	To Be C	17. Father's Name (First, Middle, Last, Joseph Shia				18. Mother's Na	me (First, Middle, ne Shia			
, Mary	and 2 sho ealth and I n 27 is ma ier trauma		19a. Informant's Name/Relationship (Carol Taylor/D			ailing Address <i>(Street</i> 789 Sewar					
timore	Pages 1 tment of H tant: If iter ijury or oth		20a. Method of Disposition 1 □XBurial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify	y)	Junior (sposition (Name of Frematory or other place Order Cemet	ery Jan		20c. Location Presto	n, Mar	ryland
Bal	permit Depar Impor any In		21. Signature of Funeral Service Licer	- , CFSF		22. Name and Addre	ss of Facility Fr n St., F	amptom H ederalsb	uneral ourg, M	Home, D 2163	P.A.
and the second	Physician with physician and physician street its private in private its priva	Examiner	23a. Part1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Uisease or Injury that initiated events resulting in death) Last	one cause on each line.	U (A) nsequence of):	M LSS	g, such as cardia	c or respiratory a	rrest,		Approximate Interval Between Onset and Death
O. Box 68760,	eath certi attending for use a	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown	d	Fetal death	3 ☐ Ectopic pregnanc 5 ☐ Other (specify) _	у			late of delive	rry Day Year
rds, P.	w requires that the d been signed by the should be detached	by	Part II. Other significant conditions of	ontributing to death but no	t resulting in the	e underlying cause give	en in Part I.				e cause of death? ably 4 🗌 Unknown
Division of Vital Records,	74 17	Completed						24a. Was autop perfo 1 □ Yes	rmed?	prior to con death?	psy findings available inpletion of cause of
Ζ	Physician: r this certific ral director,	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital: 1 ☐ Inpatient	2 □ EB/Outpa	tient 3 DOA Othe	0.51	ath <i>(Check only c</i> Home 5 ☐ Resid		ther /Specifi) Hospice
ion of	nding Ph ith. : After thi e funeral o	tion: T	27. Manner of Death 1 ⚠ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Ye	28b. Time	e of 28c. Injury		28d. Describe I			" Hospite
Divis	To the Hospital or Attending Physician: whith 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - building, etc. (S	At home, farm, pecify)	street, factory, office		28f. Location (8 City or Tox	Street and Nun vn, State)	iber or Rural	l Route Number,
	To the Hospital of within 24 hours an To the Funeral D completely filled in	Medical	29a. Certifier 1. ☐ Certifying Ph (Check only one) 2 ☐ Medical Exam	ysician: To the best of miner: On the basis of exa and manner stated.	y knowledge, de imination and/o	eath occurred at the tir r investigation, in my o	me, date and plac pinion, death occ	e, and due to the urred at the time,	cause(s) and r date and place	manner as st , and due to	tated. the cause(s)
	To t To t Com	Σ	29b. Signature and title of certifier	J. Ine	zeh		e number 3253		29d. Date sign		Day, Year) 5, 2010
	Sta	te	30. Name and address of person who TIMOTHY SNIE 3 31. Date filed (Month, Day, Year)	1 040	136	Lednum	AUE	Presto	n, N	10 7	21655
	Develope		144 6 004		1 1						

DHMH 17 Rev 1/2001

ORIGINAL

K05

			1 - State Registrar		(Certificate	of D	eath		Re	g. No. 2	010	00515
			1. Decedent's Name (First, Middi	le, Last)						Date of Deat		Year	3. Time of Death
н	Physicia /Medic		Mildred	Faulder						nuary	Day 1, 2	2010	7:25 P ™
and of	Examin		4a. Facility Name (If not institutio	n, give street and number,		4b. City, To	wn, or L	ocation of [Death		1	nty of Death	
meri!			Ravenwood Luth	eran Village		Hagers					Wash	ningtor	
	Funeral		5. Social Security Number	6. Sex 7. Ag	ge (In yrs. last birtho	Months D		If Under 24 Hours	Hrs. 8. Min.	Date of Birth (Month, Day, t. 17,	Year)	9. Birthp Cour	
	Director		219-05-2348	TLIM ZULF	95 Yr	S			0c	t. 17,	1914	Mary	land
	pu »		Usual Residence of Decedent 10a, State 10b, County		10c. City, Town of	r Location	_					1	0d. Inside City Limits
	sho	'n											1 XYes 2 □ No
	Ba-f	Director	Maryland Washir	ngton	Hagersto	Wn 10f, Zip Co	ode .			1	Da Citizon	of What Cour	ntry?
	Vith th	Ρ	10e. Street and Number			'				'			id y :
	s 23s	eral		Orive	From in III C	217		nonio Origin	a? /Cnacify	· Voo or No	U.S	Race - Americ	can Indian
	item	Funeral	11. Marital Status	12. Was Decedent Armed Forces	Ever in U.S.	 Was Decedent If Yes, specify 	Cuban,	, Mexican, F	Puerto Rica	an, etc.)		Black, White,	
36	, or	by F	1 ☐ Never Married 2 ☐ Mar 3 ☑ Widowed 4 ☐ Divorced	If Ves Give	NO .	1 □ Yes 2	No	Specify:			Spe	ecify: Whi	te
21215-0036	72 hours after death with the Maryland natural", or items 23a or 28a-f show lisal Examiner must be institled at			nt's Education	16a. D	ecedent's Usual (Occupati	ion			16b. Kind o	f Business/In	
15	in 72 n "na	Completed	(Specify only highe	est grade completed)		Give kind of work of ife. DO NOT use	done du retired)	ring most o	f working	1			
772	within jiene. r than "	E	Elementary/Secondary (0-12)	College (1-4or	5+)	Sa1	.es				Re	tail	
ğ	e filed val Hygid I other vent, III	Be C	17. Father's Name (First, Middle,	Last)				18. Mother's	s Name (Fi	irst, Middle, M	laiden Suri	name)	
<u>a</u>	ld be lenta ked ic ev	70 B	Urban George	Crist				Audre	ey Č	atheri	ne H	lower	
Maryland	2 should be and Mental is marked of aumatic ever	-	19a. Informant's Name/Relations	ship (Type. Print)	19b. M	Mailing Address (S	Street an	nd Number	or Rural R	oute Number	City or To	wn, State, Zip	Code)
ž	d 2 i 7:i		Constance Coss	/ Daughter	13	915 Rov	er N	Mill !	Road	West F	riend	ship,	MD 21794
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		20a. Method of Disposition		20b. Place of D	isposition (Name crematory or othe	of er place)	, ;	Date		20c. Location	on - City or To	own, State
9	Page: ent o nt:		1 Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (5					1	16/20	10	Uncar	ctoun	Maryland
≣	artm ortan injui		21. Signature of Funeral Service		Rest n	22. Name and	Address	of Facility	Rest	Haven	Fune	ral Ch	apel 21742
ã	Depar Impo any ir		17 7.1	5		1601 Pe							
			23a. Part 1. Enter the disease, o	r complications that cause	d the death. Do no								Approximate Interval Between
	Dhusisian		shock, or heart failure. List Immediate Cause (Final	t only one cause on each l	ine.	custes	u .	oli St	2010	0 .			
Y.	Physician /Medical		disease or condition resulting in death)	a. Due to (or as	a consequence of		0	- 45 6					
1	Examiner			Che	ronary s a consequence of	obstri	10	nue	aui	wan	y d	Isnet	se
		ē	Foque many list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		a consequence of						J		-
1	uted d ansit	Ē	cause. Enter Underlying Cause (Disease or injury that initiated events	S .									
Č.	n an ial-tra	Examiner	resulting in death) Last	Due to (or as	a consequence of	:							
68760,	icate be executed physician and the burial-transit	g		d.									
68	The law requires that the death certificate be executed ate has been signed by the attending physician and age 2 should be detached for use as the burial-transit	Medical				-					1	1_	
Box	andin use		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		o 🗆 Estania nua					23d.	Date of deliv	ery
m	deatl	icia	in the past 12 months? 1 □Yes 2 ☑No	4 ☐ Pregnant	2 ☐ Fetal death at time of death	3 ☐ Ectopic pres 5 ☐ Other (spec						Month	Day Year
P.O.	t the by th ache	Physician/	9 ☐ Unknown	9 □ Unknown					- 01				
Α,	ned ped e	by P	Part II. Other significant condition	ions contributing to death	but not resulting in t	he underlying cau	ise giver	n in Part I.		23e. Did to	oacco use	contribute to t	the cause of death?
ğ	quire an sig uld b	b b							_ 4	1 □ Y	es 2 🗆 N	lo 3□ Pro	bably 4 🔀 Unknown
00	s bec	ete								24a. Was a		4b. Were auto	opsy findings available
æ	The la te ha	Completed				•				autops perfori	ned?	death? 1 □ Yes	mpletion of cause of
Division of Vital Records,		a)	25. Was case referred to medica	al I				26. Place o	of Death (C	1 □ Yes Check only on	2 [X No	1 🗆 1 62	2 110
5	Physician: r this certifica ral director, p	m	examiner? 1 ☐ Yes 2 ☑ No	Hoenital:	ient 2 🗆 ER/Outr	atient 3 🗆 DOA	Other					Other (Speci	f(v)
ō	a Phy er thi eral c	n: To	27. Manner of Death	28a. Date of In	ury 28b. Tii		c. Injury Work?			I. Describe he			
on	Attending ir death. ector; After by the fune	Ę.	1 Natural 5 ☐ Pendi 2 ☐ Accident invest	ng (Month, D igation	ay, rear) III	ury M		es 2 □ No	0				
/isi	Atter	ij	3 ☐ Suicide 6 ☐ Could	not be 28e. Place of Ir	njury - At home, farn tc. <i>(Specify)</i>	n, street, factory, o	office		28f.	Location (S	treet and N	umber or Rur	al Route Number,
á	al or s afte I Dire	Certification:	4 Homicide determ	building, e	itc. (Specify)					City or Tow	i, State)		
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.			ing Physician: To the bes									
	n 24 n 24 ne Fu	edical	(Check only 2 Medica one)	I Examiner: On the basis and manner s		or investigation, i	n my op	inion, deatr	n occurred	at the time, o	late and pla	ace, and due	to the cause(s)
	To the within 2 To the complet	ğ	29b. Signature and title of certific	PK .		29c. l	License	number		2	9d. Date si	igned (Month	Day, Year)
	-) IAI'D	12		I	000	6611	6		1/	4/10.	
	0		30. Name and address of person	n who completed cause of	death (Item 23a) (T						4 .0	A	1 /7 -
	7		Dr. Modalle		68 mue	ype, Print) STEER	(, }	teege	Shoc	DN, N	10	,217	90
*	Sta	ite	31. Date filed (Month, Day, Year		trar's Signature	77. 4							
	Registi	ar	JAN 14 2010) Canara	B. Strank	and the second							
		0.5		7	100								

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Carrie Belle Grove January 2010 1:47 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 810 Dewey Ave. Washington Hagerstown Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) 1 □ M 2 😾 Months Days Hours Min. (Month, Day, av 9 Director 88 212-24-7369 May West Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event. the Medical Eventuals. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 ☐ No MD Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 810 Dewey Ave. 21740 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14 Bace - American Indian Armed Forces?
1 ☐ Yes 2 💢 No Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 X No Specify: Specify: White 3 X Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Program College (1-4 or 5+) Elementary/Seconday (0-12) Instructor Dental Assistant æ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ Chester Clayton Keyton Beulah Virginia Wright 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Andrea E. Whittington/Daughter 1086 Carriage Hill Parkway, Annapolis, MD 21401 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 🛛 Other (Specify) Entombment Hagerstown, MD Rest Haven Cemetery 1/8/2010 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave., Hagerstown, 21742 it ins that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complic Approximate Interval Between shock, or heart failure. List only one Immediate Cause (Final Onset and Death Atheroschusis Ph sician/ disease or condition resulting in death) Medical Medical Examiner Due to (or as a consequence of) Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence on signed by the attending physician and d be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day Pregnant at time of death Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>Ş</u> 2 No 3 Probably 4 Unknown 1 Tes Completed completed filled in by the funeral director, page 2 should 24b. Were autopsy findings available 24a. Was an autopsy performed Yes 2 prior to completion of cause of death?

1 Yes 2 No Hospital or Attending Physician: The 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify, Hospital 2 1 Inpatient 2 ER/Outpatient 3 IDOA After this 27. Manner Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred Natural injury 5 Pending death. Accident Investigation after death Suicide
Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signate 29c. License number 29d. Date signed (Month, D0056783

State Registrar DHMH 17 Rev 7/2009 11110 Medical Campus Rd., Suite 130, Hagerstown,

21742

erson who completed cause of death (Item 23a) (Type, Print)

32/Registrar's Signature

<u> Hurwitz</u>

Jeffřey

Date filed (Month, Day, Year,

MD

Examiner The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely

death with the Maryland

3altimore, Maryland 21215-0036

State

DHMH 17 Rev 1/2001

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

th. Day. Year) and manner stated.

NMS

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

lec

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

Healthcare 4014 Marsh Pike Hoyersown Mo 21742

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

00518 State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 7:30P M Donald Elbridge Grove 2010 Jan. 3, /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Monkton Baltimore 733 Monkton Road | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Dey, Year July 20, 1 Birthplace (Stete or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1X M 2 □ F 79 213-28-5333 MD Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Items 23e or 28a-f ahow other traumatic avant, the Medical Examiner round be notified at 1 TYes 2 XNo Director Baltimore Monkton 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 733 Monkton Road 21111 U.S.A. Completed by Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. ent If item 27 is marked other than "natural", or Items 23. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1951 Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify. If Yes, Give Year or Dates: White 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) State Road Elementary/Secondary (0-12) College (1-4or 5+) Laborer Department 18. Mother's Name (First, Middle, Maiden Sumame, 17. Father's Name (First, Middle, Last) George W. Grove Elsie E. Kopp 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) George Grove/Brother 733 Monkton Rd, Monkton, MD 21111 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, Stete Jan. Monkton united 1 Burial 2 □ Cremation 3 □ Removal from State ō permit. Page Department of Importent: If any injury or Monkton, MD * 4 □ Donation 5 □ Other (Specify) Methodist Cemetery 2010 22. Name and Address of Facility J.J. Hartenstein Mortuary Inc. 24 Second Street, New Freedom, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final **Physician** resulting in death) /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Physician/Medical Examiner The law requires that the death certificate be executed use as the burial-transit oranan P.O. Box 68760% that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? jo Month Day Year 5 Other (specify) should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. Completed by 4 Unknown 3 Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? page 2 Division of Vital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 1 ☐ Yes 2 No Certification: To 5 Sesidence 6 Other (Specify) funeral dir this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 1 Natural 5 Pending s after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident the 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 1 4 - Homicide Within 24 hours a To the Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signat State Registra

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 00519 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month Day Year A M January 6, 2010 Genevieve Neville Howell 8:30 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 22370 Colton Street St. Mary's Leonardtown 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, May 2, 7. Age (In vrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** 1 □ M 2 😿 F Months Days Hours Min 1918 Director 557-01-2592 91 District of Columbia Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits traumatic event, the Medical Evantiner must be notified at Director 1 ☐ Yes 2 K No St. Mary's Maryland Leonardtown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 3 death with 39608 Lady Baltimore Avenue 20650 USA Funeral or items, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2K No þ Specify: Specify: White 3 ☐ Widowed 4 🔀 Divorced n and Mental Hygiene. Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) U.S. Government Head Hospital Cashier 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert Francis Handley, Sr. ပ္ Genevieve Cecelia Gannon 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important; If item 27 is any injury or other trau once. Genevieve H. Taylor / Daughter 22370 Colton Street Leonardtown, MD 20650 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. Francis Xavier Date 20c. Location - City or Town, State January 9, 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2010 Compton, Maryland Cemetery 21. Signature of Funeral Service Liver ee 22 Name and Address of Facility Mattingley-Gardiner Funeral Home, P P.O. Box 270 Leonardtown, MD 20650 23a. Part 1/ Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) I or Attending Physician: The law requires that the death certificate be executed after death. attending physician and for use as the burial-trans Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ♣ No
9 ☐ Unknown 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 3 Ectopic pregnancy signed by the atte Month Day 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 XYes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □No 24a. Was an autopsy certificate 1 ☐Yes 2 No To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4☐ Nursing Home 5☐ Residence 6 Other (Specify) Residence 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 1/2001

State

BA

B. park

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D.O.

32. Pegistrar's Signature

Jennifer Schmidt,

40055751

40900 Merchants Lane Ste. 205, Leonardtown, MD 20650

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2010 2:14 p M Ε. Hamilton January Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death St. Marv's St. Mary's Hospital Leonardtown 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Days 1 M 2 K F Months Hours 0772771923 North Carolina Director Yrs. 86 246-16-6795 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10h. County 10a, State 10c. City, Town or Location 10d. Inside City Limits Funeral Director 1 ☐ Yes 2 🛣 No Maryland St. Mary's Leonardtown 10e. Street and Number 10g. Citizen of What Country? 22680 Cedar Lane Court # 2107 20650 US 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 6 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", Completed 3 Widowed 4 Divorced White Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) id Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Carrie Lee Stroud Earnest Batten and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t of Health 22680 Cedar Lane Court #2107, Leonardtown, MD 20650 Joel C. Hamilton/Spouse or other 20b. Place of Disposition (Name of cemetery, crematory or other place) Floral Garden Memorial Park 20a. Method of Disposition 20c. Location - City or Town, State Page 1 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or 01/09/2010 High Point, NC 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatura Funeral Service License 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Edward N. Brinsfield, Jr. M00052 22955 Hollywood Rd., Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician/ Acute Myocardial Infarction Medical Due to (or as a consequence of): Examiner Years Coronary Artery Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of, for use as the burial-transit Days Acute Renal Failure Cause (Disease or iiniury that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician Physician/Medical Years Chronic Renal Failure Box 68760 yes, outcome of pregnancy Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Pregnant at time of death Day Year 1 Yes 2 No signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Pulmonary Hypertension 1 Tes 2 **Y** No 3 Probably 4 Unknown been : 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an After this certificate has performed Yes 2 1 ☐ Yes 2 ☐ No 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **N**0 1 🗆 Yes ပ္ 1 Ninpatient 2 ER/Outpatient 3 DOA Certificate: Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural 5 🗌 Pending work? 1 ☐ Yes 2 ☐ No Investigation Accident the Suicide 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Division of Vital Records, P.O. To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After

State

DHMH 17 Rev 7/2009

Registrar

only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

32. Registrar's Signature

Rajbinder S. Gill,

JAN 0 5 2010

29c. License number

D56076

24035 Three Notch Rd., Hollywood, MD 20636

29d. Date signed (Month, Day, Year)

1/4/2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death January 2010^{ar} Physician/ 9:45A. Subah Ali Hussain Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard Laurel 11615 Arden Court If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8 Yrs. Social Security Numbe 8. Date of Birth 9. Birthplace (State or Foreign Funeral 351-98-6289 1 🗆 M 2 🗓 F Months NOV", 18, 42001 IfTimois Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination. 10d. Inside City Limits 10b. County 10a State 10c. City, Town or Location Director Maryland Howard Laurel 1 ☐ Yes 2 🛛 No 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number Funeral 20723 United States 11615 Arden Court 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian. 11. Marital Status Armed Forces? Black, White, etc. 1 X Never Married 2 Married Completed by 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Asian Specify: 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) elementary school student Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Sveda Batool Moosvi Waseem Hussain 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nabeen Hussain -Uncle 8621 Sunbeam Place Laurel, Maryland 20723 20a. Method of Disposition
1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)

MD National Memorial Park 1/4/2010 Laurel, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses Donald V. Borgwardt Funeral Home, PA 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of) -09 Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Day Pregnant at time of death 5 Other (specify) ned by the a edetached f q | Unknown cate has been signed by page 2 should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No certificate 1 ☐ Yes 2 🛣 No within 24 hours a er death.

To the Funeral Director: After this certific completed filled in by the funeral director, 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: To 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 27. Manner of Death 28d. Describe how injury occurred 1 X Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) Do013668 1-4-2010 macin

State Registrar 31. Date filed (Month, Day, Year)

EDGEWOOD RD. COLLEGE DARK. MD. 2640

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

USSAIN M.D

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 7:20 A M 2010 Grace Elizabeth Jackson January /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** 474 Dutchmans Lane Greensboro Caroline If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months Days Hours 1 □ M 2 🗓 F May 8, Maryland Director 214-70-7043 1959 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" or Items 23a or 28a-f show any injury or other traumatic event, the "marked Expriner" list be a life and sonce. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 14 Yes 2 □ No Directo Maryland| Caroline Greensboro 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21639 U.S.A. 474 Dutchmans Lane Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: ģ Specify: 3 ☐ Widowed 4 ☐ Noivorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Disabled 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Grace Savage Ward-Gadow 2 Hamlet Lee Ward 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Darah E. Jackson/daughter 5803 Greenpoint Rd., East New Market, MD 21631 20b. Place of Disposition (Name of cemetery, crematory, or other place)
Chesapeake Cremation
Center, Inc. 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Jan.4, 2010 Chester, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatury of Funeral Service Licensee 22. Name and Address of Facility Fleegle and Helfenbein Funeral Home, PA 106 W. Sunset Ave., Greensboro, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21639 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Probable complication of **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to for as a consequence of the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Chronic pain syndrome, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown this certificate has been sral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □ No 24a. Was an autopsy 1 ☐ Yes 2 ☑ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this funeral c 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident Director: d in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

PATRICIA

aine 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KARNES AMZIGEZ, DO

, Day, Year)

AL R 2010

Registrar's Sign

DHMH 17 Rev 1/2001

29c. License number

316 Railrad Ave PUBOX 122

29d. Date signed (Month, Day, Year)

MD

Gildshore

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time di Physician/ JÄNT.6,2070 GEORGE ANTHONY KNEIPP 2:40A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGES CLINTON SOUTHERN MD.HOSP.CENTER Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex **Funeral** Months Days Hours Min. APR 22 LA Gountry) Year 939 439-56-4986 70 **Director** Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits Director HUGHESVILLE CHARLES MD. 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7505 PAISLEY PLACE 20637 Funeral U.S.A. death 12. Was Decedent Ever in U.S.

Armed Forces?

1 X Yes 2 □ No USAF
If Yes, Give RET 20 yr S¹ □ Yes 2 XNo Specify: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 2 1 Never Married 2 XMarried 72 hours after Maryland 21215-0036 SpecifWHITE "natural", 3 Widowed 4 Divorced Completed other traumatic event, the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) U.S.AIR FORCE Elementary/Seconday (0-12) College (1-4 or 5+) Mental Hygiene. U.S.GOVT. RET.MASTER SGT. marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည FRED KNEIPP NEVELLA MITCHELL should and Me 19a. Informant's Name/Relationship (Type, Pnint) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code S 7505 PAISLEY PLACE HUGHESVILLE, MD. 20637 MARY KNEIPP-SPOUSE and 2 s Health a Baltimore, item 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 s
Department of H
Important: If ite
any injury or ot 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MD. VETERANS CEM. 1-14-2010CHELTENHAM, MD. 72. Name and Address of Facility
RAYMOND FUNERAL S
LA PLATA MARYLAND 21. Signature of Funeral Service Licensee MQ0479 SERVICE, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final set and Death Physician/ disease or condition Medical resulting in death) Due to (o Examiner Sequentially list conditions, Examine Due to (or if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed tran and Due to (or as a consequence of) resulting in death) Last physician a sthe burial-Physician/Medical Division of Vital Records, P.O. Box 68760 the attending phohed for use as the IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Pregnant at time of death 2 No g Unknown g Unknown signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2 autopsy 1 Yes 2 No Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 🗷 No 1 Yes ၉ 1 MInpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 28b. Time of I Director: After to a in by the funeral 28d. Describe how injury occurred Certificate: 1 M Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 2 No 1 Yes Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, after determined filled in within 24 hours a To the Funeral D Medical 29a. Certifier 😿 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

1× State

DHMH 17 Rev 7/2009

Registrar

29b. Signature and title of certifier

30, Name and address of person who completed cause of death (Item 23a) (Type, Print

32. Registrar's Signature

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Year Month Kauffman Elmiria Tan Virginia 1003AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Washington County Hospital Washington Hagerstown 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Month, Day, 214-48-3537 Director 62 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Me iteal Ex miner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11525 Englewood Road 21740 U.S.A. hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12, Was Decedent Ever in U.S. 14. Race - American Indian, rmed Forces? Black, White, etc. þ 1 Never Married 2 X Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired Elementary/Seconday (0-12) 12 Domestic Homemaker is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Charles Linden Howell Helen Romain Selby 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health item 27 Gene E. Kauffman, Sr./Husband permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr 11525 Englewood Road, Hagerstown, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 K Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Rest Haven Cemetery ! 1/11/2010 Hagerstown, MD 21. Signature of Funeral Service Licensee

S.Meu.C. Su. 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave., Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause Immediate Cause (Final Onset and Death Physician/ cute myocardial disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exam Cause (Disease or linjury nding physician and use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 use as 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ atter for L in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 1 ☐ Yes 2 ☐ Unknown been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Tes 2 To 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has l page 2 s autopsy performed certificate 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No မ 1 Impatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After the Hospital or Attending 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation within 24 hours after death

To the Funeral Director: completed filled in by the i 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🖺 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State

DHMH 17 Rev 7/2009

Registrar

3 29b. Signature and title of certifier

Mus- Pw 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

UND

WATTERN

29c. License number

1)21457

-12821 DAKHIII AVZ. HAGERSTOWN. MD 21742

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Kevin Levaca		S 1- For State Registrar	tate of Maryla		artment o ertificate o		nd Mental	Hygiene	Reg. No. 20	10 00525
Physicia Medical Examin	n/	Decedent's Name (First, Middle Kevin (NMN) Le	, ,					2. Date of De Month January	ath Day Year	3. Time of Death 2119 hrs
		4a. Facility Name (if not instituti Shady Grove Hospita	ion, give street and nu	umber)		4b. City, Town, o			4c. County of Montgom	
Funeral Director		5. Social Security Number	6. Sex	7. Age (In yrs.		If Under 1 Ye		Min.		9. Birthplace (State or Foreign Country)
any	ŀ	158-66-5650 Usual Residence of Decedent 10a, State 10b, County		3!	, Town or Loca			Aug.	21, 1970	New York 10d. Inside City Limits
À .⊤	į	Maryland Monte	gomery		nt Airy	10f. Zip Code			10g. Citizen of Wha	1 Yes 2 X No
th the Mar 23a or 28s notified at	al Director	26301 Mullinix				21771			USA	
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Menial Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 Never Married 2 X N 3 Widowed 4 Di		2 X No		as Decedent of Hi Yes, specify Cuba	n, Mexican, Pue	(Specify Yes or N erto Rican, etc.)	White,	
hours afte "natural" Examine	ted by	15. Decedent's Education (Specific Elementary/Secondary (0-12)	or Dates: ecify only highest grad	de completed)		nt's Usual Decupa	tion (Give kind		Specify: W	Thite iness/Industry
-0036 1 within 72 giene. ther than	Completed	12 17. Father's Name (First, Middle		1-4 01 01 7	owner	operator		ame (First, Middle,	masonry Maiden Surname)	contractor
21215-0036 Juld be filed within 7 Mental Hygiene, marked other than event, the Medica	To Be C	Joseph Peter I 19a. Informant's Name/Relation	LeVaca	ONACA Y	1-9b. Mailin	g Address (Stre	Joan Ma	rie Done	gan	State, Zip Code) 21771
e, MD 2 l and 2 shou Health and P item 27 is r traumatic	_	Manuela Palmer		Carlot:	a 2630 Place of Dispos	1 Mullin sition (Name of ce	ix Mill		ount Airy	
Baltimore, MI permit. Pages 1 and 2 s Department of Health a Important: If item 27	1	1 X Burial 2 Cremation 4 Donation 5 Other S 21. Signature of Funeral Service			1 Sou1s	Cemeter	y Ja	2010 an. 13,	Germanto	own, Maryland
		23a. Par Enter the disease, o	Due	raused the death	26	401 Ride	ge Road,	Damascu	ıs, Maryla	
Physician Medical Examiner	Ì	ailure. List only one cause Immediate Cause (Final disease or condition resulting in death)	e on each line. () e a. Arrhyth	mogenio	right			rdiomyop		Between Onset and Death
	ا _ق	Sequentially list conditions, if any, leading to immediate	b	a consequence of						
d sit	Examiner	(Disease or injury that initiated events resulting in death) Last	C.	a consequence o	of):		_			
0, be executed sician and burial - transit	edical E	X UNPENDED	d AMENDED	23a,27,	perME,	g900 2/4	4/10 TT			
0 2	ΣΙ	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Ur	the 23c. If yes,	outcome of pregointh nant at time of	gnancy 2 Fe	etal death 3 ther (Specify)	Ectopic pre		23d. Date of do Month	elivery Day Year
P.O.	اھ	Part II. Other sionificant condi	tions contributing to	o death but not i	resulting in the (underlying cause	given in Part!	23e Did		ute to the cause of death? Probably 4 ✓ Unknown
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the safter death. In Director: After this certificate has been signed by led in by the funeral director, page 2 should be detactly.	Completed							1 ✓ Yes	psy pried? dea	ere autopsy findings available or to completion of cause of ath? Yes 2 No
Vital Rec hysician: The this certificate	o Be	25 Was case referred to medical examiner? 1 ✓ Yes 2 No		Inpatient 2	ER/Outpatient		Other Nu	rsing Home 5	Residence 6	Other:
ion of tending Pheeath	ation: T		28a. Date (Month estigation	of Injury n, Day,Year)	28b. Time of		ury at Work? Yes 2 No	28d. Describe	how injury occurred	1
Divis pital or At ours after d ceral Direct filled in by	Certification:	3 Suicide 6 Cou			nome, farm, stre	et, factory, office	building, etc.	28f. Location or Town,		or Rural Route Number, City
Division To the Hospital or Attent within 24 hours after death To the Funeral Director:	Medical	Concer only	Physician: To the bes aminer: On the basis and manner s	of examination a	_					
	ž	29b. Signature and title of certifi			MI	29c. Licens O.C.		<u>.</u>	29d. Date signed Jan∪ary 9, 2	(Month, Day, Year)
		30. Name and address of person Russell Alexander Mi	D Assistant M	Medical Exar	miner 111	Penn Street	, Baltimore,	MD 21201		
Sta Registr		31. Date filed (Month, Day, Year	10 Lever	egistrar's Sonat	ure	0				

10-00068	
Jimmy Morgan	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Jimmy Morgan		State of Maryland / Department of Health and Mental H Certificate of Death		eg. No. 2010	00526
Physicia Medical Examir	n/	1. Decedent's Name (First, Middle, Last) Jimmy Allen Morgan	2. Date of Dea Month January 3	th Day Year	3. Time of Death 1625 hrs
	er h	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 1437 Walnut Bottom Road Swanton	1	4c. County of Death Garrett	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs Months Days Hours Min	┥ .	Co	thplace (State or Foreign untry)
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	ţor	MD GARRETT SWANTON 10e. Street and Number 10f. Zip Code	I 1	0g. Citizen of What Cou	1 Yes 2 No
the last	Director	1437 WAINUT BOTTOM RD. 21561		U.S.A.	
r death w	Funeral	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Sp. 14. Was Decedent of Hispanic Origin?) (Sp. 15. Was Decedent of Hispanic Origin?)		White, etc.	ican Indian, Black,
hours after 'natural'', c	盃	3 Widowed 4 Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of voluming most of working life. DO NOT use retired.		Specify: 16b. Kind of Business/I	117E
)036 within 72 iene. er than '	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) TECHNICIAN 17. Father's Name (First, Middle, Last) 18. Mother's Name	/First Middle	AUTOMO	TIVE
21215-(uld be filed v Mental Hygi marked oth	Be	ARVILLE L. MORRAN EDN	A Col	lins	7. 0. 1.)
e, MD 21 1 and 2 should I Health and Mer item 27 is man	٤	19a. Informant's Name/Relationship (Type, Ptflt) 19b. Mailing Address (Street and Number or R 1215 STEVENS AVE. ARBU	STUS, M	D. Z 1227	
Baltimore, Moemit. Pages I and 2 Department of Health Important: If item 2 njury or other traun		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 4 Denation 5 Other Specify:	7-10	20c. Location - City or	
Baltimo permit. Page Department of Important: injury or oth		21. Stiffulling of Funeral Service Licensee 22. Name and Address of Facility AL MOOG 42 Abol MOUNTAIN RD-P	SOLERTY	FUNERAL HO	ME 2
Physician /Medical	7	2 Fart I. Enter the rise se, or complications that caused the death. Do not enter the mode of dying, such as cardiac of failure. List only one cause on each line. Immediate Cause (Final disease a. Hypertensive atheroscleortic cardioval)			Approximate Interval Between Onset and Death
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Division of Vital I To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certif completely filled in by the funeral director.	⊢ ŀ	27. Manner of Death 1 X Natural 5 Pending 2 Accident Investigation 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No	28d. Describe I	how injury occurred	
Division pital or Attend ours after death teral Director:	Certification:	3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (\$ or Town, S	Street and Number or Ru State)	ral Route Number, City
Di To the Hospital within 24 hours To the Funeral I	Medical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and when the course of examination and/or investigation, in my opinion, death occurred and manner stated.			
	ğ	29b. Signature and title of certifier 29c. License number O.C.M.E.		29d. Date signed (Mo) January 4, 2010	nth, Day,Year)
oxpend		30. Name and address of person who completed cause of death (Item 23a) Russell Alexander MD. Assistant Medical Examiner 111 Penn Street, Baltimore, M	D 21201		
Sta Regist		31. Date filed (Month, Day, Year) 32. Registrar's Signature And 2010			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Physician/ Moebius Richard F. Janua 11.07 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Hagerstown Washington County Hospital | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Min. | Month | Day, Year) | 1933 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 X M 2 - F Chicago, IL 327-28-2037 Director 76 Usual Residence of Decedent ul Hygiene. I other than "natural", or items 23a or 28a-f show vent, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits the Maryland Director Blue Ridge Summit, PA 1 Yes 2X No Frankln 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral be filed within 72 hours after death with 17214 13223 Stahley Rd. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 X Married þ Maryland 21215-0036 1 Yes 2 X No Specify white Completed 3 Widowed 4 Divorced Year or Dates. 1953-1984 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) U.S. Army soldier 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental F ည Waltraut Fischer Fredich Carl Moebius and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2552 Nicky Lane Alexandria, VA 22311 Department of Health ar Important: If item 27 is any injury or other trau Alexandria, 2552 Nicky Lane Leah Moebius Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Page 1 s cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Waynesboro, PA 01/08/2010 4 Donation 5 Other (Specify) Antietam Cemetery Grove-Bowersox Funeral Home, Inc. 21. Signature of Fundal Service Licensee 22. Name and Address of Facility Waynesboro, PA 17268 50 S.Broad St. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine If any, leading to immedit cause. Enter Underlying burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last To the Funeral Director: After this certificate has been signed by the attending physician completed filled in by the funeral director, page 2 should be detached for use as the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 Yes 2 9 Unknown 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕱 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No death? 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2X No မှ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1X Natural 5 \square Pending 1 🗌 Yes 2 🗆 No Accident Investigation 24 hours after death Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) the 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D6899 1/4 York lang 10

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Registrar

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31. Date filed (Month, Day, Year)

Hazerstown,

MD 21740

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1130

spal court

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State Registrar 11

32. Registrar's Signature

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30. Name and address of person who completed cause of death (Item 23a) (Type

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iculcal Exam	IIIEI	Kaysea Shane Mor				4b. City, Town,	or Location o	January		I U Ic. County of Death	
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Funeral		Social Security Number 6. S		(In yrs. las	st birthda	y) If Under 1 Y	ear If Unde	er 24Hrs. 8. Date of	Birth(MN	A/DD/YYYY) 9. Bir	thplace (State or
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		Usual Residence of Decedent			15	113.		02/	16/19	994	, MD
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n with ms 23 be no	1 2	11. Marital Status	12. Was Decedent B	ver in U.S	. 13	. Was Decedent of I	Hispanic Orig	in? (Specify Yes or		14. Race - Ameri	can Indian, Black,
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s after	É		d If Yes, Give Year or Dates:		1	Yes 2X				Specify: Whi	
hour frant		15. Decedent's Education (Specify of				edent's Usual Occup ng most of working I			16b.	Kind of Business/I	ndustry
36 in 72 han t	를	Elementary/Secondary (0-12)	College (1-4 or 5-	')	Νo	ver Worke	a			Momo	
-00. I with	Completed	17. Father's Name (First, Middle, Las			Ne	ver worke		s Name (First, Middl	e Maide	None	
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by MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland feath and Mental Hygiene. tend? is marked other than "natural", or items 23a or 28a-f she rraumatic event, the Medical Examiner must be notified at once	일	19a. Informant's Name/Relationship (Type, Print)		19b. M	ailing Address (Str	l .	ber or Rural Route			, Zip Code)
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If tien 27 is marked other than injury or other reaumatic event, the Medical		20a. Method of Disposition			ace of Di	sposition (Name of or other place)		Date		. Location - City or	
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Baltin permit. P Departme Importan injury or		21. Signature of Funeral Service		1	1	22. Name and Addre	ss of Facility		100		,
E P P E		profit.				R.T. Foar	d Fune	eral Home,	P.A	A. мп 2101	1
Physician		23a. Part I. Enter the disease, or comfailure. List only one cause on e	plications that caused the	ne death. [o not en	ter the mode of dyin	g, such as ca	ardiac or respiratory	arrest, sf	nock, or heart	Approximate Interval Between Onset and
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		MI	- 12 M	7		0.0	M.E.		Jai	nuary 7, 2010	
10		30. Name and address of person who		•	,						
		Russell Alexander MD.	Assistant Medica			I11 Penn Stree	t, Baltimo	re, MD 21201			
	tate	31. Date filed (Month, Day, Year) JAN 1 1 2010	32. Registrar's	Signature	-	1					
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		Registrar				Cer	tificate	OT D	eatn 			Reg. No	UIU	00330
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Funeral Director		5. Social Security Number 218-24-9495	6. Sex] м 2 🖾 F	7. Age (In yrs. I	ast birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Birl (Month, Da April 24	y, Year)	9. Birth Cour Mary	place (State or Foreign htry) 1 and
		Usual Residence of Deced	ent								nprii 2	1700	1 11112)	
and shov	힏	10a. State 10b. 0	County		10c. Cit	y, Town or Loc		_						10d. Inside City Limits
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		30. Name and address of	71 . [se of death (Iter	n 23a) (Type, F	Print)	LJ	401	4	<u> </u>	Jines	1	7
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 0:54 AM **Physician** 2010 January /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Town, or Location of Death Examiner Agnes Baltimore 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F Months MARYLAND Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shot traumatic event, The Modeal Examination as 1 ☐ Yes 2 ☑ No Director 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 823 CEDAR BRANC 5.A Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 11 Marital Status 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates:52-58 1 □Yes 2 No Maryland 21215-0036 Specify: WhITE Specify: ð 3 ☐ Widowed 4 ☑ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) U.S. POSTAL SERVICE 18. Mother's Name (First, Middle, Maiden Surname) ₩ K 17. Father's Name (First, Middle, Last) Be 2 should be finance and Mental F permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 is marked t any injury or other traumatic ew once. ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3637 Washington Rivo. Halethorse, MD . 21227
Date 20c. Location - City or Town, State BERTC Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 5 ☐Other (Specify) W, ARUNDEL CREMATORY 1-5-10
22. Name and Address of Facility TAUSHERT 4 ☐ Donation ODENTON MD. Y FUNERAL HOME MODGUZ DOOMOUNTAIN AD PASADENA Part1. Enter the diseas shock, or heart failure. Approximate Interval Between Onset and Death or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line Immediate Cause (Final disease or condition resulting in death) **Physician** rose psi Days /Medical Due to (or as a consequence of): Examiner Failhre Day Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) Examine burial-tran Due to (or as a consequence of): attending physician アラン CMAYIRS H. Division of Vital Records, P.O. Box 68760 Physician/Medical the as nse If yes, outcome of pregnancy
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9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for t in the past 12 months? 5 Other (specify) 1 ☐Yes 2 ☐ No been signed by the should be detached 9 I Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ≥ -oronary Artery Disease, Diabeter Mellitus, 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tyes Completed pertension, Parkinsons Disease 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ဥ this 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital or 1 critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number ,0 anuary hannen 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9 Caton Avenue Baltimore, MD21229

State Registrar

DHMH 17 Rev 1/2001

Charles

igrelli

Jannarose

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Physician 2010 dwin Jar /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Elkton Count If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Oct 29 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Year 1**∑** M 2□ F Yrs Director 220-34-7501 1938 Delaware Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be realished at 1 ☐ Yes 2 No Director Cecil Earleville MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21919 2 Florida Ave. U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any lijury or other traumatic event, the Marical Experiment. 1 GYes 2 No 1956 If Yes, Give Year or Dates: -1959 1 ☐ Never Married 2 → Married Saltimore, Maryland 21215-0036 White 1 ☐ Yes 2X No Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Episcopal Priest Religion 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Edwin Pippin Mary Pryor 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elsie T. Pippin (wife) 2 Florida Ave. Earleville, MD. 21919 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 1/12/2010 Smyrna, DE. Odd Fellows Cem. 4 Donation 5 Dother (Specify) 21. Sig afure of Flurral Service Licensee Galena Funeral Home of Stephen L Schaech 118 West Cross St. Galena, MD. 21635 M00510 Approximate Interval Between Onset and Death Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Caure (Final Physician 5 days unaemic disease or condition resulting in death) /Medical Due to (or as consequence of): Examiner lalnutritio Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Metastatic as the burial-transit and Due to (or as a consequence of) Box 68760, physician Physician/Medical ed by the attending letached for use as IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) P.O. I □Yes 2 □No 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed After this certificate has been funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform of Vital 1 ☐ Yes 2 INo 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Npatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Mannef of Death 1 ☑ Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 2 Accident filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar 31. Date filed (Month, Day, Year)

JAN 1 4 2010

30. Name and a dress of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

, III W. High St. Ste 203, Elkton, MD LONE MD 32. Registrar's Signature

29c. License number

DO058347

29d. Date signed (Month, Day, Year)

Jan 6, 2010

White, etc. Married 1 Yes 2 No No Specify: Married 1 Yes 2 No No Specify: Middle No No No No No No No N				
Medical Examiner FERNANDO PARRA-MENDEZ 4a. Facility Name (if not institution, give street and number) 8803 Barnsley Court, Apt 11 Funeral Director NONE Usual Residence of Decedent 10a. State 10b. County PARRA-MENDEZ 4b. City, Town, or Location of Death Laurel 4b. City, Town, or Location of Death Laurel Funder 1 Year Month January 1, 2010 4c. County of Death Prince George's 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or ForeignTLAPACO Country) VERACO Cou				
4a. Facility Name (if not institution, give street and number) 8803 Barnsley Court, Apt 11 5. Social Security Number NONE 1 X M 2 F 42 Yrs. 4b. City, Town, or Location of Death Laurel 4c. County of Death Prince George's 4c. County of Death Prince George's 4d. City, Town, or Location of Death Prince George's 4d. City, Town, or Location of Death Prince George's 4d. County of Death Prince George's	—— (4A)			
Director NONE 1 X M 2 F 42 Yrs. Months Days Hours Min. 01-01-1968 ForeignTLAPACO Country) VERAC Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City	¥AŊ			
NONE Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City	ילווא			
10a. State 10b. County 10c. City, Town or Location 10d. Inside City				
MD PRINCE GEORGE LAUREL 1	Limits			
10e. Street and Number 8803 BARNSLEY COURT #11 10e. Street and Number 8803 BARNSLEY COURT #11 11. Marital Status 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White, etc. MEXICAN Specify: 15. Decedent's Education (Specify only highest grade completed) 16. Street and Number 10e. Street and Number 8803 BARNSLEY COURT #11 11. Marital Status 1 Yes 2 No 3 Widowed 4 Divorced 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No 1 No specify: 1 Specify: 1 Specify: 1 Street and Number 1 Specify: 1 Street and Number 1 Specify: 1	_ No			
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Write, etc. MEXICAN Specify: Write, etc. MEXICAN Specify: 1 X Never Married 2 Married 3 Widowed 4 Divorced 1 Yes 2 Xes 2 X	14. Race - American Indian, Black,			
3 Widowed 4 Divorced of Yes, Give Year 1 Yes 2 No specify: Specify				
15. Decedent's Education (Specify only highest grade completely) 16. Decedent's Education (Specify only highest grade completely) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 18. Mother's Name (First, Middle, Maiden Surname) 19. CANTINO BARRA LOZANO				
PRIVATE STOCKER PRIVATE 18.Mother's Name (First, Middle, Maiden Surname) LUCIA MENDEZ-CASTELLANOS				
18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 18. Mother's Name (First, Middle, Maiden Surname)				
TERREL Shraytho DARDA LOZANO LUICIA MENDEZ-CASTELLANOS				
MAXIMO PARRA-LOZANO LUCIA MENDEZ-CASTELLANUS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)				
19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) VERONICA GARCIA ORDUNO/FRIEND 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) VERONICA GARCIA ORDUNO/FRIEND 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) VERONICA GARCIA ORDUNO/FRIEND 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)				
20a. Method of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition (Name of cemetery, crematory or other place)				
TLAPACOYAN, VERACRU Donation 5 Other Specify: DOLORES CEMETERY 01-14-2010	Z			
20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: 21. Signature of Funeral Service Lice see 22. Name and Address of Facility JB JENKINS FUNERAL HOME				
Approximate I	nterval			
failure. List only one cause on each line Acute otherol intoxication Death	et and			
Immediate Cause (Final disease or condition resulting in death) Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):				
Sequentially list conditions, b				
cause. Enter Underlying Cause				
Description of the past 12 months? We see the properties of the past 12 months? We see the properties of the past 12 months? We see the properties of the past 12 months? When the past 12 months? When the past 12 months? When the past 12 months? We see the properties of the past 12 months? When t				
23a,27,28a-1, perfix, go 7 1/13/10 11 23d. Date of delivery				
Very serious forms of the seri	ır			
The first of the post 12 months? We will be seen to graph of the past 12 months? We				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death of the cause of the cause of death of the cause of t				
OL 15 08 08 08 08 08 08 08 08 08 08 08 08 08	3-2-0			
24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No 1 Yes 2	se of			
O Place of Death (Check only one) 1 ✓ Yes 2 No 2 N	No			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Yes 2 No 3 Probably 4 Unk				
24a. Was an autopsy performed? 1				
Yes 2 No ingested alcohol beverage investigation Fd 1/1/2010 unk				
Note: The state of	r, City			
AMENDED AME				
29b. Signature and title of certifier 29c. License number O.C.M.E. January 2, 2010				

State Registrar DHMH 17 Rev 1/2001 OCME 2006

31. Date filed (Month, Day, Year)

JAN 0 6 2010

Security 5. Registrar's Signature

111 Penn Street, Baltimore, MD 21201

30. Name and address of person who completed cause of death (Item $\overline{23a}$)

Ana Rubio MD. Assistant Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month January Physician/ 2019b 2:45 Рм Melvin Delano Phillips Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Frederick Frederick Frederick Memorial Hospital 9. Birthplace (State or Foreign Country) Maryland 6. Sex 1 X M 2 C F 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral Days Hours March 22° 73 217-32-7017 Director Usual Residence of Decedent show 10d. Inside City Limits 10c. City, Town or Location 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hyglene.

Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State Director 1 Tyes 2 X No Tuscarora Maryland Frederick 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral United States 4131 Rock Hall Road 21790 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race ~ American Indian 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 X No Black, White, etc. 1 Never Married 2 XMarried Completed by Maryland 21215-0036 1 Tes 2 X No Specify: White Specify: If Yes. Give 3 Widowed 4 Divorced Year or Dates 15 Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) 12 College (1-4 or 5+) State Government Sanitarian Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Mary Kathryn Stewart C. Lee Phillips 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4131 Rock Hall Road, Tuscarora, Maryland 21790 Shirley Phillips / Wife Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition January 5, permit. Page 1 a
Department of H
Important: If ite
any injury or otf 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Paul's Cemetery 2010 Point of Rocks, Maryland 21. Signature of Funeral Service Licensee Keeney and Basiord PA Funeral Home, MO1473 Church Street, Frederick, Maryland 21701 l106 E. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 1eH middle cerebral artery Physician/ disease or condition resulting in death) Medical) Mean Examiner Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) for use as the burial-transit Cause (Disease or liniury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death ed by the a detached f g 🗌 Unknown 9 Unknown P.O. care has been signed by the page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 11a 1 Yes 2 No 3 Probably 4 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed' certificate Yes 2 No 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗹 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 28a. Date of injury (Month, Day, Year) 27. Mann of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 No ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier □ Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated □ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated □ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D32073 2010

15

State Registrar 610 Ninth are.

Brunswick

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hem

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene n n 5 3 5 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year Eleanore Plummer 0645 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Payonal MedCen umberland an 9. Bittiplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 M 2 D Months Min. Month, Day, Director Ohio 218-24-83348 Usual Residence of Decedent 10a. State 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Allegany Cumberland 1 ☐ ¥es 2 ☐ No 23a or 2 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21502 10301 Christie Road USA items death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 11. Marital Status 14. Race - American Indian, ō Black, White, etc. Completed by 1 Never Married 2 Married 72 hours after Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: permit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exa If Yes, Give Year or Dates Specify: 3 XVidowed 4 Divorced white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) retired seamstress Local Garment Ind. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Robert William McKnight Idella Festerman McKnight 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD 21557 Debra Hout daughter 18113 McMullen Highway Rawlings Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Frostburg Memorial Park 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 1/8/2010 MD 4 ☐ Donation 5 ☐ Other (Specify) Frostburg 21. Sign e o Fareral Service Licensee 22. Name and Address of Facility
Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Immediate Cause (Final Onset and Death Physician/ atera disease or condition neumonia 2 weeks Medical resulting in death) Due to (or as a consequence of Examiner ecruentially list nunditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of). resulting in death) Last Physician/Medical law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death been signed by the should be detached 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably Wunknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy perform this certificate 1 Yes 2 No Yes 2 25. Was case referred to medical Division of Vital Hospital or Attending Physician: funeral director. Be 26. Place of Death (Check only one) examiner? 2**X** No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ 📈 Inpatient 2 🗌 ER/Outpatient 3 🗌 DOA 27. Manner of Death 28b. Time of Certificate: 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred After 1 Natural (Month, Day, Year) 5 Pending after death. 1 Yes 2 No Accident Investigation completed filled in by the Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Hospital within 24 hours a To the Funeral D Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29c. License number 29d. Date signed (Month, Day, Year) monsonfiller

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registr

00055325

p walsh Rd cumberland MD 21502

Jan 06, 200

10-00014 Elisa Nicole Prelov	1	y S - For State	pe or Print i tate of Maryla	and / Depa		of Healt	h ar					20	10	00536
Physician Medical Examine	1/	Registrar Registrar Reg. NO.												3. Time of Death 1600 hrs
		4a. Facility Name (if not institution, give street and number) 1435 Millwood Court 4b. City, Town, or Location of Death Arnold Anne Art												
Funeral Director												MM/DD/YYYY) 9. Birthplace (State or		
the Maryland a or 28a-f show any tified at once.	Ī	Usual Residence of Decedent 10a. State										10d. Inside City Limits 1 Yes 2 No izen of What Country?		
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland rent of Health and Mental Hygiene. nnt: If item 27 is marked other than "natural", or items 23a or 28a-f show any or other traumatic event, the Medical Examiner must be notified at once.	ᅙ	1110 Severnview Drive 21032 11. Manital Status 1 \overline{\infty} \text{Never Married} 2 \overline{\infty} \text{Married} 2 \overline{\infty} \text{Married} \frac{12. Was Decedent Ever in U.S.}{1 \overline{\infty} \text{Yes}} 13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto) \frac{13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto) \frac{13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto) \frac{13. Was Decedent of Hispanic Origin? (Sp. If Yes, Specify Cuban, Mexican, Puerto) \frac{13. Was Decedent of Hispanic Origin? (Sp. If Yes, Specify Cuban, Mexican, Puerto) \frac{13. Was Decedent of Hispanic Origin? (Sp. If Yes, Specify Cuban, Mexican, Puerto) \frac{13. Was Decedent of Hispanic Origin? (Sp. If Yes, Specify Cuban, Mexican, Puerto) \frac{13. Was Decedent of Hispanic Origin? (Sp. If Yes, Specify Cuban, Mexican, Puerto) \frac{13. Was Decedent of Hispanic Origin? (Sp. If Yes, Specify Cuban, Mexican, Puerto) \frac{13. Was Decedent of Hispanic Origin? (Sp. If Yes, Specify Cuban, Mexican, Puerto) \frac{13. Was Decedent of Hispanic Origin? (Sp. If Yes, Specify Cuban, Mexican, Puerto) \frac{13. Was Decedent of Hispanic Origin? (Sp. If Yes, Specify Cuban, Mexican, Puerto) \frac{13. Was Decedent of Hispanic Origin? (Sp. If Yes, Specify Cuban, Mexican, Puerto) \frac{13. Was Decedent of Hispanic Origin? (Sp. If Yes, Specify Cuban, Mexican, Puerto) \frac{13. Was Decedent of Hispanic Origin? (Sp. If Yes, Specify Cuban, Mexican, Puerto) \frac{13. Was Decedent of Hispanic Origin? (Sp. If Yes, Specify Cuban, Mexican, Puerto) \frac{13. Was Decedent of Hispanic Origin? (Sp. If Yes, Specify Cuban, Mexican, Puerto) \frac{13. Was Decedent of Hispanic Origin? (Sp. If Yes, Specify Cuban, Mexican, Puerto) \frac{13. Was Decedent of Hispanic Origin? (Sp. If Yes, Specify Cuban, Mexican, Puerto) \frac{13. Was Decedent of Hispanic Origin? (Sp. If Yes, Specify Cuban, Mexican, Puerto) \frac{13. Was							n, Puerto R		.) White, etc.			
2 hours after "natural", (Examiner	라	3 Widowed 4 Di 15. Decedent's Education (Spe Elementary/Secondary (0-12		de completed)	16a. Decede during r	nt's Usual (nost of work	Occupa king life	tion (Give	kind of wo		16b	Specify: . Kind of Bus	siness/ I r	ite
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than c event, the Medica	- 1	17. Father's Name (First, Middle Michael J. Pre	3 o, Last)			N	<i>Y</i>		r's Name (I		e, Maide	en Surname)	NA	
Baltimore, MD 21215-00; permit. Pages I and 2 should be filed with Department of Health and Mental Hygiene Important: If titem 27 is marked other thinjury or other traumatic event, the Med To Re Comm		19a. Informant's Name/Relation Michael J. Pre	ship (Type, Print)					et and Nur	mber or Ru	ral Route N		City or Town		
Baltimore, hermit. Pages I and Department of Healt Important: If item injury or other trau	1	20a. Method of Disposition 1 Burial 2 X Crematic 4 Donation 5 Other S	n 3 Removal fr	rom State At					Jan. 201	0		Location - Glen B	urni	le, MD
Balti permit. Departu Import injury o	1	21. Signature of Funeral Service 23. Part I. Enter the disease, o	ALC r complications that of	aused the death	n. Do not enter	Name and Arrance 05 GoV the mode o	Addres 7 F f dying	s of Facilit Son: Litch: such as c	s, P. ie Hw	A. Ser y, Ser	verr verr	na Par na Par hock, or hea	k Fi k, N	neral Home 1D 21146 Approximate Interval
We die al Examiner		failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	_{a Narcoti}	c (hero		toxica	atio	on						Between Onset and Death
ted Insit		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Inluded events resulting in death) Last	ē	a consequence o						_				
760, ficate be executed g physician and the burial - transit	= -	X UNPENDED		23a,27,2 outcome of preg		erm,E	g9(00 2/	5/10	TT	12	3d. Date of	delivery	
). Box 68760, the death certificate be exery the attending physician a cohe for use as the burial. Physician/Modica	lysician/n	3b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 V Ur	he 1 Live t	oirth nant at time of de	2 Fe	etal death ther (Spec	3 ify)	Ectopi	c pregnand	Э		Month	D	ay Year
S, P.O. E unites that the d in signed by the detached by Physical	2	eart II. Other significant condi	tions contributing to	o death but not r	resulting in the	underlying	cause	given in Pa	art I.	1 🗌 Y	es 2	✓ No 3	Proba	
tal Records, leian: The law requires certificate has been signetor, page 2 should be Commisted.	ad line									per 1 ✓ Yes	opsy formed	pr ? de		opsy findings available ompletion of cause of S
F Vital Physician or this certinal director		25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1	Inpatient 2	ER/Outpatien	t 3 🗌 DC	DA	Other ₄		Home 5		dence 6	_	Scene
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transported Contributed by Dhysician/Madical Endication: To Be Completed by Dhysician/Madical Endication	erillication	27. Manner of Death Natural S Pending Investigation Accident Suicide Suicide Homicide Homicide Accident Homicide Accident Homicide Accident Homicide Accident Homicide Accident Specify House Accident Specify Accident Accident											al Route Number, City	
To the Hosp within 24 host To the Fune completely fi		29a Certifier 1 Certifying P	hysician: To the besominer:On the basis and manner s	of examination a	_									
		29b. Signature and title of certifications of the Mayonie The	Mayerie Melhell O.C.M.E.							January 2, 2010				th, Day, Year)
		30. Name and address of person who completed cause of death (Item 23a) Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201												
Stat Registra	e S	31. Date filed (Month, Pay Year	32. R	gistrar's Signati		are								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ JANUARY 6 201 dear 10:33 Рм JAMES REID R Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** FREDERICK FREDERICK FREDERICK MEMORIAL HOSPITAL 8. Date of Birth (Month, Day, Year Nov. 15. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Months Days 87 Hours North Carolina 1 ₹ M 2 □ Director 244-14-1889 Nov. Usual Residence of Decedent 28a-f shov 10b. County 10d. Inside City Limits 10a. State 10c. City. Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at Director Maryland Frederick Frederick 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21701 403 Birmingham Drive 12. Was Decedent Ever in U.S. Arged Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married If Yes, Give 1942-1946 Year or Dates. Completed by Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired)

Postal Worker/Clerk (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) US Postal Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Madge Shankle James Ralph Reid, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Louise P. Reid, wife 403 Birmingham Drive, Frederick, MD 21701 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Arlington National Cem. Feb. 1, 2010 Fort Myer, VA 4 Donation 5 Other (Specify) 21. Signature Truneral Service Lice ²² Reeney and Basford PA Funeral Home 106 East Church St., Frederick, MD 21701 M00255 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of): been signed by the attending physician and should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Month Pregnant at time of death 5 Other (specify) Unknown 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 s autopsy death? Yes No certificate 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific.
completed filled in by the funeral director, I To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Hospital or Attending (Month, Day, Year) 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number. 4 Homicide determined Medical Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title

State Registrar 31. Date filed (Month, Day,

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 – For State Registrar	State of Maryland / D		rtment of I				giene Reg. No2 0	0 1 1	00538		
	Physici /Medic		1. Decedent's Name (First, Middle, Last) EUSEBIO N/M/	N REYES					2. Date of Dea		Year	3. Time of Death 2:10A M		
San	Examin		4a. Facility Name (If not institution, give s CHARLOTTE HALL			4b. City, Town, C	TTE 1	HALL		ST.M	ty of Death	S		
	Funeral Director		5. Social Security Number 106-32-6280 Usual Residence of Decedent	7. Age (In yrs. last birth	hday) (rs.	Months Days	If Under Hours	24 Hrs. Min.	8. Date of Birt (Month, Da 1 1 – 1 9	1924	9. Birth	place (State or Foreign Intry) AS		
	Maryland -f show find at	tor	10a. State 10b. County MD . ST . MARY	10c. City, Town		cation FTE HAL	L					10d. Inside City Limits 1 □ Yes 2 No		
	h with the 23a or 28a	al Director	10e. Street and Number 29449 CHARLOTT	E HALL ROAD		10f. Zip Code 206	22			10g. Citizen o		intry?		
0000	ges 1 and 2 should be filed within 72 hours after death with the Maryland if of Health and Mental Hygiene. If of Health and Mental Hygiene. or other traumatic event, the Medical Examination and to invitind a protection.	by Funeral	11. Marital Status 1 Never Married 2 XMarried 3 Widowed 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No USAF IfYes, GiveRET . 3 UYr Year or Dates:	13. W	Vas Decedent of H i Yes, specify Cub X□Yes 2 □ No			cify Yes or No Rican, etc.)	BI	ace - Amer lack, White, sify: WHI	ican Indian, etc. TE		
7-61717	d within 72 ho giene. er than "natu	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 1 2	College (1-4or 5+)	(Give k life. D	lent's Usual Occup kind of work done DO NOT use retire T . TECH	during mos d)	st of workin	ng	U.S.A	16b. Kind of Business/Industry U.S.AIR FORCE U.S.GOVT.			
	2 should be file n and Mental Hy Is marked oth raumatic event	To Be (17. Father's Name (First, Middle, Last) JORGE REYES	JORGE REYES TEOFILA SA										
_	d2.emthal		19a. Informant's Name/Relationship (Type GUADALUPE REYES-	WALD	Route Number, City or Town, State, Zip Code) WALDORF, MD. 20602									
Dalthiiore	permit. Pages 1 an Department of Heal Important: If Item 2 any Injury or other once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	ARLINGT	'ON	sition (Name of natory or other pla NATION	AL C	EM.1	-28-1	20c. Location ARLI				
ם מ	permit Depar Impor any Irr		21. Signature of Funeral Service License	Kunk		Name and Addre AYMOND A PLATA	FUNE:	RAL 206	46		۷.	Approximate		
	Physician /Medical Examiner	er	23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to immediate.	cause on each line.	<u> </u>	ER'S				illest,		Interval Between Onset and Death		
,0070	To the Hospital or Attending Physician; The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	dical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last d.	Due to (or as a consequence o	of):									
. O. DOX	that the death certific hed by the attending p detached for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)								wery Day Year		
ords, r	quires that en signed t uld be deta	þ	Part II. Other significant conditions con	ributing to death but not resulting in FYPERTENSIO		derlying cause gi	ven in Part I	l.		obacco use co ∕es 2 □ No		the cause of death?		
מום וש	Attending Physician: The law requir core of After this certificate has been si by the funeral director, page 2 should I	Completed	CEREBRO VASCO	1 □ Yes	rmed? 212 No	prior to c death?	opsy findings available ompletion of cause of							
=	nysicia nis certi directo	To Be	25. Was case referred to medical examiner?	ospital: 1 ☐ Inpatient 2 ☐ ER/Out	tpatient	t 3 DOA Otl	or:		(Check only one 5 ☐ Resi	<i>nne)</i> dence 6 □C	Other (Spec	ify)		
5 :	ding Pl After ti funeral	ion:	27. Manner of Death 1. Natural 5 ☐ Pending 2 ☐ Accident investigation		ime of njury	Wo	ryat rk?]Yes 2□		28d. Describe	now injury occi	urred			
חואות :	tal or Atten s after deatl al Director: ed in by the	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	eet, factory, office	1100 2		28f. Location (S City or Tox		mber or Ru	ral Route Number,				
N	To the Hospital within 24 hours a To the Funeral I completely filled	edical	29a. Certifier 1 Certifying Phys (Check only one)	cian: To the best of my knowledge er: On the basis of examination and and manner stated.	, death d/or inv	occurred at the t vestigation, in my	ime, date a opinion, dea	nd place, ath occurr	and due to the ed at the time,	cause(s) and date and place	manner as e, and due	stated. to the cause(s)		
1	To the Within To the compl-	Med	29b. Signature and title of certifier			29c. Licen				29d. Date sign		-		
),	141		30. Name and address of person who con	mp	Type 5		0677	188		1.5	. 20	010		
	H1,		LEENA RAO KO	DALI	iype, r	THIQ								
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signature		4 4								

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 2010 7:40 A M Joyce Elaine Roe January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Caroline Greensboro 466 Dutchmans Lane If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🛣 F Director 13, 1948 Pennsylvania 218-48-5823 61 Jan. Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1X Yes 2 ☐ No Director Maryland| Caroline Greensboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 466 Dutchmans Lane 21639 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2K Married Baltimore, Maryland 21215-0036 1 □Yes 2X No Specify: ģ 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within ment of Health and Mental Hygiene. ant: If Item 27 is marked other than 'ury or other traumatic event, In a Ma Elementary/Secondary (0-12) College (1-4or 5+) 12 Seamstress Clothing Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ Medford Carpenter Margaret Emma Short 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any Injury or other tra 21639 205 N. Academy St., Greensboro, Maryland Amy Lynn Dixon/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)
Chesapeake Cremation
Center, LLC 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Jan.6,2010 Chester, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fleegle and Helfenbein Funeral Home, PA 106 W. Sunset Ave., Greensboro, Maryland 21639 Leps 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 10 Cardia Sudden dierth disease or condition resulting in death) /Medical (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 5010-Examiner or Attending Physician: The law requires that the death certificate be executed intetes and burial-tra Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy þ in the past 12 months? Month Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No the 9 Unknown þ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Yes 2 No 3 Probably 4 Unknown director, page 2 should Completed 24a. Was an autopsy performed Were autopsy findings available prior to completion of cause of death? has certificate rethr 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 \sum Nursing Home Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Aesidence 6 ☐ Other (Specify) this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After 1 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation within 24 hours after deatl To the Funeral Director: filled in by the ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) evi-to 31. Date filed (Month) 32. Registrar's Sig State Registrar

B1

DHMH 17 Rev 1/2001

Registrar

It Lot 1

Box 68760

P.O. I

DHMH 17 Rev 7/2009

Hancisco

31. Date filed (Month, Day, Year)

Daniels

DO

Magerstown

21740

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Robert 1:01 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** University of Mary land Medical Center Baltimore Baltimore If Under 1 Year | If Under 24 Hrs. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Min. Hours 1 ₺ M 2 🗆 F 1 1 - 0 3 - 1 9 4 9 Pennsylvania Director 204-40-3211 Usual Residence of Decedent iral", or items 23a or 28a-f shov Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director PA Franklin Chambersburg 1XXYes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 357 E. Washington Street 17201 USA Apt.1 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ 1 ☐ Yes 2 🛣 No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 No Specify. white Specify: "natural", Completed 3 Widowed 4 Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the Owner/Operator Retail Sales 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William H. Rapp Jr. Glenda Grace Madden should be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh
Department of Health ar
Important: If item 27 is
any injury or other trau Elizabeth Tarner 2904 Regina Drive, Silver Spring, MAryland (sister) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Norland Cemetery 20c. Location - City or Town, State ★XX Burial 2 ☐ Cremation 3 ☐ Removal from State 01-07-2010 | Chambersburg, PA. 17201 4 ☐ Donation 5 ☐ Other (Specify) Signature of Femeral Service Licenses 22. Name and Address of Facility 333 Falling Spring Rd. M01346 Thomas L. Geisel F.H. Chambersburg, PA. 17202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Athenosdenotic heart disease Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions Due to (or as a consequence of) if any teach g to himsolate cause. Enter Underlying Cause (Disease or iinjury that initiated events as the burial-transit Due to (or as a consequence of): 命 resulting in death) Last attending physician Physician/Medical certificate be Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy Po in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No the detached 9 Unknown P.O. I þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ate has been signed page 2 should be del þ End Stage renal disease Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Septicemia 24a. Was an performed? Phenmonia certificate 2 No 1 Yes Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certific funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **N** No မှ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural (Month, Day, Year) 5 Pending work' 1 ☐ Yes 2 ☐ No 2 Accident the -Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) two anny 1942468384 01/01/2010

DHMH 17 Rev 7/2009

State Registrar Street Baltimore, MD 21201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

South Greene

32. Registrar's S

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 💚 📗 📗 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Luvina L. Smith Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 9. Birthplace (State or Foreign Country) Western MD Regional Medical Cumberland f Under 1 Year | If Under 24 Hrs. 8. Date of Birth Funeral Days (Month, Day, Year) 1 M 2 X F Months Hours Min 271-34-1917 71 Director 1938 Ohio Usual Residence of Decedent show ä 10a. State 10b. County 10c. City. Town or Location Director 10d. Inside City Limits or 28a-f sl notified 1 🗌 Yes 2 🔀 No Allegany Frostburg 10e. Street and Numbe 10f Zin Code 0 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27: is marked other than "natural", or items 23a on any filury or other traumatic event, the Medical Examiner must be. Funeral 21532 10144 Colebank DriveNW U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black White etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 13 College (1-4 or 5+) Elementary/Seconday (0-12) Health Care Nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Dorothy Hale Douglas Hale 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $10144\ Colebank\ Drive\ NW\ Frostburg,\ MD\ 21532$ Gary Smith husband 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Cumberland Crematory 20c. Location - City or Town, State Date 1 🗆 Burial 2 🕱 Cremation 3 🗀 Removal from State 1-10-2010 Cumberland, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Sowers Funeral Frostburg, MD 60 W. Main St., rewers M00547 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) Medical uence of Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying a consequence of or Attending Physician: The law requires that the death certificate be executed Dause (Disease of Injury the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician hed for use as the burial Physician/Medical dular cod IF FEMALE. 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 9 Unknown 9 Unknown P.O. 1 ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 🗆 Yes 2 No 3 Probably 4 Dunknown page 2 should peen s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 16 this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? 2 2 No 1 Pinpatient 2 □ Certificate: To ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 P Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death permedyat the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation (Check in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death urred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hrrisueno 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 14 2010 Registrar DHMH 17 Rev 7/2009

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 00543 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year Physician/ 04.23 am Steven Ellis Swadley Januar Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Washington County Hospital Hagerstown 9. Birthplace (State or Foreign Country) 8. Date of Birth
(Month, Day, Year)
July 5,1962 5. Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Hours 1 🕅 M 2 🗆 F Ju<u>ly</u> Director 161-54-8861 Usual Residence of Decedent 28a-f shov 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Exa<u>miner must be notified at</u> 10a. State 10b. County 10c. City, Town or Location Director 1 🗆 Yes 2 🌠 No Fulton Mercersburg PA 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 17236 USA 654 Big Cove Tannery Road 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No If Yes, Give 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. permit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exal Specify: 3 Divorced 4 Divorced White Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Retail Sales Farm Machinery Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Shirley A. Litton Robert E. Swadley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 654 Big Cove Tannery Road Mercersburg, PA 17236 Betty J. Swadley/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 💢 Cremation 3 ☐ Removal from State Smithsburg Crematory 01/05/2010 4 Donation 5 Other (Specify) Smithsburg, MD 21. Summure of Funeral Se 22. Name and Address of Facility 141 West Main Street Grove Funeral Home, P.A. Hancock, MD 21750-0368 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one dause on each line. 23a. Part 1. Enter the disease, or co Approximate Interval Between Onset and Death Immediate Cause (Final Physician Soft tissur Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): sician and burial-transit Exam certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: nse 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 - Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ To the Hospital or Attending Physician: The law requires that the death within 24 hours after death.

To the Funeral Director: After this certificate has been sign-d by the atter completed filled in by the funeral director, page 2 should be detached for users. in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part L 234. Did tehacoo use objetribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 🗌 Yes 2 🗐 No Yes 2 Ch 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ည 27. Manner of Death 28b. Time of 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) Natural 5 Pending work? 1 Yes 2 No Accident Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 41667 Mulan

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Michael McCornack 11110 Me

32: Registrar's Signature

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND TTEM#18perINF, G904, 671072010, WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** January 6, 2010 11:43 P M Mary Jane Scully /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner St. Mary's Hospital Leonardtown St. Mary's If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year May 30, 19 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 🔀 F 213-22-0755 86 1923 Maryland Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 1XYes 2 □ No Director St. Mary's Leonardtown Maryland 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 20650 USA 41655 Church Street Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔼 No Specify: Specify: White ģ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18 Mother's Name (Eirst, Middle, Maiden Surname) Adelaide Maria Lynch Margaret Adelaide Lyn 17. Father's Name (First, Middle, Last) Be Benjamin Kennedy Abel1 ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 24429 Mervell Dean Road Hollywood, MD 20636 Mary Leone Gatton /Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date January 11, 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. Aloysius Cemetery 2010 Leonardtown, Maryland 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.O. Box 270 Leonardtown, MD 20 21. Signature of Funeral Service License Tichae 23a. Part 1 Enter the disease, or complications thet caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical consequence of : **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be execu burial-tra Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month Day 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ò 1 ☐ Yes 2 1 → 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy 1 ☐Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 1 D Matural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 2 01/07/2010 BA Name and address of person who completed cause of death (Item 23a) (Type, Print) 26800 Pour Lookord Rd Leonard Yourges ROBYN Browne

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State

Registrar

31. Date filed (Month, Day, Year)

JANO?

2010

ORIGINAL

10-00061 Francis Scott Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ncis Scott	State of Maryland / Department of Health and Mental Hygiene												
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dical Exami		Francis 4a. Facility Name (if not institution	Edward		, Jr.	lb. City, Tow	n, or Location o		odiladi y o	4c. County o	f Death	n	
		27195 Beker Road	ii, give sa cot and ii			Denton				Caroline			
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. la	ast birthday)	If Under			8. Date of Bin	th (MM/DD/YYYY)	I Foreig	an	1
Director		219-02-0999	1X M 2 F	42	Yrs.	Months	Days Hours	Min.	Sept. 2	2, 1967	Co	^{ountry)} Mar	ryland
		Usual Residence of Decedent										10d. Insid€	City Limits
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and show	ō		ent	D	over	10f. Zip C	ode		I1	0g. Citizen of Wh	nat Cou	untry?	
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ath with the Maryland items 23a or 28a-f show any ust be notified at once.	io i	156 Karl Dr		acedent Ever in U.	S 13. Wa	s Decedent	901 of Hispanic Orig	gin? (Spe	cify Yes or No		- Ame	rican Indian,	Black,
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215- be filed ntal Hyg rked otl	Be C	Francis		rd Scot	t, Sr.		Mar	tha	Ann M	lowbray			
212 ould be Ment mark	To E	19a. Informant's Name/Relation	ship (Type, Print)							mber, City or Tow			
MD d 2 sho lith and n 27 is	ľ	Deby Scott		Wife	156 Place of Dispos	Karl	Drive,	<u>Dove</u> i	r, Dela Date	ware 10	- City (or Town, Stat	e
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department and Mortal Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service	Macia	d St	reet. I	enton. 1	Mar	vland	21629				
		23a, Part I. Enter Me disease, o	or complications that	respiratory ar	rest, shock, or he	art	Approxii	mate Interval n Onset and					
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id ou	<u> </u>	29a Certifier	Physician: To the	best of my knowle	edge, death oc	curred at the	e time, date and	place, and	d due to the ca	ause(s) and mann	ner as	stated.	e)
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7. 12. 12.	3	29b. Signature and title of cer		$\frac{1}{n}$	1050	29	c. License numb	ær		January	-		/
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		30. Name and address of per- Victor Weedn MD J		cause of death (It Medical Exar	_{em 23a)} niner 111	Penn S	treet, Baltim	ore, MD	21201				
				Registrar's Sign									
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2010 Yea Physician/ January 1 5:40 pmM Pear1 Marv Virginia Skeggs Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** County of Death 17601 Garrett Drive Gaithersburg Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Feb 2. 1922 1 DM 2 1 F Days Min 219-14-8026 Marvland Director 87 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director Maryland Frederick Frederick 1XX Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funera 240 Wyngate Drive 21701 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 X No Black, White, etc. þ 1 X Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify. Specify: White Completed 3 Divorced Year or Dates the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Administrative Insurance Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F t. Page 1 and 2 should be fill trent of Health and Mental rant; If item 27 Is marked Ray **Elva** Mae Rhoderick Downey Skeggs Anna traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17601 Garrett Dr, Gaithersburg, Maryland 20878 Mr. Albert Marcey, Cousin permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other to once. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Burial 2 ☐ Cremation 3 ☐ Removal from State Mt Olivet Cemetery Jan 6, 2010 Frederick, Maryland 4 ☐ Donafon 5 ☐ Other (Specify) Signature of Funeral Service Literal ee 22. Na Keeney& Bastord P.A. Funeral Home M00706 106 East Church St, Frederick, Maryland Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) Due to (or as a conseque ce of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) Due to (or as a consequence of): resulting in death) Last -purialattending physician Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 as the IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? for Month Day Year Pregnant at time of death the detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by pe or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown page 2 should been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed' certificate 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Cousins Other: 4 Nursing Home 5 Residence 6 X Other (Specify) Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Home: filled in by the funeral 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After (Month, Day, Year) Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner; To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and He of certifie 29c. License number 29d. Date signed (Month, Day, Year) D16428 30. Name and address of eted cause of death (Item 23a) (Type, Print) who comple DA 300 West Ninth St, Frederick, Maryland 21701

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed Month, Day, Year

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2010 Diane S. Satterfield РМ 1330 January Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 225 Elkmore Road Ceci1 E1kton Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, 8. Date of Birth Funeral 1 □ M 2 🕅 F Months Days Hours Min. (Month, Day, Yea West Virginia Director 58 222-36-5775 April Usual Residence of Decedent 28a-f show 10a. State 10b. County Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Exminer must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Ceci1 E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21921 225 Elkmore Road United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. Completed by 1 Never Married 2 X Married 2 X No Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White If Yes, Give 3 🗆 Widowed 4 🗆 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Administrative Supervisor Flooring Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Herman Stuiber Patricia Woods 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ralph Satterfield/Husband 225 Elkmore Road, Elkton, MD 21921 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State January 8, 4 Donation 5 Other (Specify) R. A. Ferris & Co., Inc. :2010 West Chester. 21, Signature of Funeral Service Licensee 22. Name and Address of Facility
Hicks Home for Funerals, Stockton Street, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate
Cause (Disease or iinjury Due to (or as a consequence of): Exami attending physician and for use as the burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death 5 Other (specify) g 🗌 Unknown detached P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ should be Records, 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performe Yes 2 1 ☐ Yes 2 🗙 No Division of Vital or Attending Physician: filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 24 hours after death. Funeral Director: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Name and address of person who completed cause of death (Item 23a) (Type, Print

State Registrar

23a or 72 hours after death 21215-0036

> Physician /Medical Examiner

be executed physician and s the burial-trans 68760, Box P.O. Division of Vital Records,

00548 1 - For State Registrar Reg. No 2010 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) JANUARY Day 2010 3:25 pm EVELYN S. M. SMITH 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Kent Chestertown Nursing & Rehab Chestertown | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Apr 1 0 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** England 1 □ M 2 🗗 F 084-34-9590 Apr 94 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show traumatic event, the Mictigal Exerciner round be notified at 1√ Yes 2 No Director MD Kent Chestertown 28a-f 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 3 Reed Court Great Britain 21620 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 If Yes, Give 1 □Yes 2 □No Specify. þ Specify: White 3 XWidowed 4 ☐ Divorced Year or Dates Completed permit. Pages 1 and 2 should be filed within 72 l Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "... any injury or other traumation." 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Interior Decorator Self-employed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frederick Hagger Susan Seymour ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jan Macdonald (daughter) 108 High St. Chestertown, MD. 21620 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/6/2010 Kent Cremation Smyrna, DE. 21. Signature of Funeral Service Licens Galena Funeral Home of Stephen L Schaech M00510 118 West Cross St. Galena, MD. Approximate Interval Between Onset and Death 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause Final DEMENTI > 5 year disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of) Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🔼 No Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 Probably 4 Unknown FAILURE TO THRIVE Were autopsy findings available prior to completion of cause of death? 24a. Was an Was a... autopsy performed? Ves 2 2 No 1 ☐ Yes ≥ Z No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending within 24 hours after usa....

To the Funeral Director: Af 1 ☐ Yes 2 ☐ No investigation 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and little of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Helen A. Noble, M.D. 122 Speer Rd. Chestertown, MD. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 1 1 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ January 2010 Year Charles William Swaniger, 9:14 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 50 Appeal Lane, Apt. 104 Calvert Lusby 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Days Months 1 월 M 2 □ F Hours Min. Washington. 01/15/1954 214-60-6437 Yrs Director 55 Usual Residence of Decedent Show 10a. State er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 M No Maryland Calvert Lusby 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 50 Appeal Lane, Apt. 104 20657 United States within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: White If Yes Give Specify 3 Widowed 4 X Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Auto Mechanic Auto Repair Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Charles William Swaniger, Sr. Delores Jean Vernon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1970 Rye Court, Lusby, Maryland 20657 Pam Garner (Sister) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Metropolitan Crematory 1/4/2010 Alexandria, Virginia 4 Donation 5 Other (Specify) Rausch Funeral Home, P.A. 21. Signature of Funeral Service Lifense 22. Name and Address of Facility P. O. Box 600, Lusby, Maryland 20657 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition 5 ms Medical resulting in death) Examiner Due to (or as a consequence of) Sequentially list conditions. cause. Enter Underlying Cause (Disease or linjury Due to lor as a consucuence of or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last physician a the burial-Physician/Medical attending p use as IF FEMALE: yes, outcome of pregnancy ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Year Day Pregnant at time of death 4 ☐ Pregnant 9 ☐ Unknown 1 Yes 2 L 9 Unknown the been signed by 1 should be detact Part II. Other significant conditions contributing 6 eath but not result 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an s certificate has t director, page 2 s autopsy performed? Yes 2 0 No 2 🗌 No 1 Yes 25. Was case referred to medical director, 26. Place of Death (Check only one) Be examiner? Hospital 2 No Other: 1 Yes ၉ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this hin 24 hours after death.

the Funeral Director: After thi

mpleted filled in by the funeral 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check

State Registrar DHMH 17 Rev 7/2009

within 2

only one

29b. Signature and title of Certifie

31. Date filed (Month, Day, Year,

M.D

32. Registrar's Signatu

Maryland 21215-0036

Baltimore.

P.O. Box 68760

Records,

Division of Vital

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

20678

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** January A M Evelyn Irene Scheiber 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Fahrney Keedy Memorial Home Washington County Boonsboro If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Hours 1 □ M 2 X F 100-22-0095 20,1927 NewYork Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show r than "natural", or items 23a or 28a-f shov 1 ☐Yes 2X No Director Maryland Washington County Boonsboro 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 8507 Mapleville Rd. 21713 Funeral filed within 72 hours after death 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2X No Specify Specify: White Completed by 3 Nidowed 4 □ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Housekeeper School for the Blind 12 should be filed w th and Mental Hygier 7 is marked other tt other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ivan Huber Amelia Eaton Huber 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health at
Important: If item 27 is
any Injury or other trau Pages 1 and 2 13421 Wellspring Dr. Hagerstown, MD 21740 Linda S. Attavian-daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Smithsburg Crematory 1-5-2009 Smithsburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that cause of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear realiure. List only one cause on each line. 1331 Eastern Blvd. North Hagerstown, MD 21742 Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Menmonia 0 disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cluss (15635 or 17 july) that initiated events resulting in death) Last Due to (or as a consequence of) Examine Physician: The law requires that the death certificate be executed and I-tran physician a s the burial-t Due to (or as a consequence of): Box 68760, Physician/Medical attending philips at the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year signed by the a d be detached for 5 Other (specify) 0 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an page 2 autopsy performed? certificate director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Available Available 1 Besidence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient Medical Certification: To of this After this funeral of To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director; After th completely filled in by the funeral 27, Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Division Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifie 🛱 🖵 🗬 Tifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 05H-5 Muhammad Khalid Waseem, 1126 Opal Court, Hagerstown, MD 21740 31. Date filed (Month, Day, Year) gistrar's Signature State JAN 05 2010 Registrar

DHMH 17 Rev 1/2001

Fvelyn

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2010 1:55 A January Earl Houck Stouffer /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington Hagerstown Ravenwood Lutheran Village If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6 Sev 7. Age (In yrs. last birthday) **Funeral** Days 1XXM 2□ F 213-18-8191 90 Yrs 13,1919 Director Nov. Maryland Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a, State 10b. County "natural", or items 23a or 28a-f show stical Examiner must be notified at 1 ☐ Yes 2 ☑ No Maryland Washington Co. Director Hagerstown 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 22019 Grove Road 21742 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 X Married 200No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: White þ 3 Widowed 4 Divorced Completed er than "natur, 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Tool Planner Aircraft Mfg. 7 is marked other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles Stouffer Katherine Beitler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 23506 Ringgold Pike, Smithsburg, MD 21783

Date | 20c. Location - City or Town, State Health a tem 27 is Dennis Stouffer/Son Department of Health Important: If item 27 any injury or other tr. once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State Rest Haven Cemetery Jan. 4,2010 | Hagerstown, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licenses 1331 Eastern Blvd. N. Hagerstown, MD 21742 Ducinlas A 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) mostale cancer metastatic Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to inmediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): physician at the burial Division of Vital Records, P.O. Box 68760, Physician/Medical aftending pt 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month in the past 12 months? 5 Other (specify) 1 ☐Yes 2 ☐ No been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ₹ A 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b irector, page 2 sl autopsy performed? 1 □ Yes 2 ⊡ No 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 1€ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death.
To the Funeral Director: A completely filled in by the fu 2 Accident 6 ☐ Could not be 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number MD 1/4/10 DO066116 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mergerstown MD .21740 Anddeeh Ali . 368 MILL ST. SHIL

State

Registrar
DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 00552 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Janua Janua 4:40 PM Dorothy Ann Sponseller Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington County Hospital Hagerstown Washington 5. Social Security Number If Under 1 Year I If Under 24 Hrs. 6 Sex 7. Age (In yrs. last birthday) 8 Date of Birth Birthplace (State or Foreign Country) Funeral 1 🗆 M 2 🏝 0970571929 220-26-7318 80 Director WV Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director ms 23a or 28a-f s must be notified MD Washington Williamsport 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 17308 Tamarack Drive 21795 US 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 5 Completed by 1 Never Married 2 Married 1 Yes Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify: 3 Nidowed 4 □ Divorced Specify: Year or Dates the Medical 15. Decedent's Education. 16a, Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) ed other than " event, the Med Elementary/Seconday (0-12) College (1-4 or 5+) id Mental Hygiene. marked other thai Telecommunications Specialist Telecommunications Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Joseph Taylor Griffith Frances Cecilia Henry and lis mo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) S. Jay Sponseller / Son 227 Galewood Drive, Edgewater, MD 21037 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Page 1 Important: If it any injury or o once, 1 Burial 2 Cremation 3 Removal from State St. Pauls Cemetery 01/07/2010 Clear Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Euneral Service Licensee 22. Name and Address of Facility Gerald N. Minnich Funeral Home 305 N. Potomac Street, Hagerstown, MD 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause __each line. Moult Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Completed by Physician/Medical I or Attending Physician: The law requires that the death certificate be enter death.
Linector After this certificate has been signed by the attending physicial use as 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 month Pregnant at time of death Month Day Year signed by the af d be detached for 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed 1 ☐ Yes 2 ☐ No 25. Was case referred to media Certificate: To Be 26. Place of Death (Check only one) Hospital: Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 2 □ No 1 🔲 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death 28h Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 \square Pending 1 🗌 Yes 2 🗌 No Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner To the best of my lin 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type Print) Suite wo Hagustown MD 21740 ANTIETOM 5H-20

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month

P.O. Box 68760

Records,

Division of Vital

Baltimore, Maryland 21215-0036

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Division of Vital Records, P.O. Box 68760,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death	To the Fundus area ocean. To the Fundus area become After this certificate has been signed by the attending physician and completely filled in by the fundual director, mana 2 should be detached for use as the burial-transf

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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State of Maryland / Department of Health and Mental Hygiene 2 [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2010 Physician/ Martha Ann Turnage 8:10 \mathbf{P}_{M} January Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death St. Mary's Hospital Leonardtown Mary's Social Security Number If Under 1 Year **Funeral** 7. Age (In vrs. last birthday) If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🕱 F Months Days Hours North Carolina 238-22-3015 Director 87 Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2X No Maryland St. Mary's Great Mills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20634 21724 Garfield Street USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc 1 Never Married 2 Married ģ Maryland 21215-0036 ☐ Yes 2 X No If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: White 3 XWidowed 4 Divorced Specify: Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Ohio University Educator 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Charles Nicholas Allen Lona Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Russell Turnage / Son 8529 Hicks Island Road Lanexa, VA 23089 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 \blacksquare Burial 2 \square Cremation 3 \square Removal from State January 9, 4 ☐ Donation 5 ☐ Other (Specify) Montlawn Memorial Park 2010 Raleigh, North Carolina 21. Signature of Funeral Service Line Name and Address of Facility
Mattingley-Gardiner Funeral Home, P.A.
Leonardtown, MD 20650 ucha 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Physician/ Onset and Death disease or condition MINUTES Medical resulting in death) Examiner CORO DISEASE Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence on YEARS To the Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-transit DEMENTIA that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Day Year 9 Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed? Yes 2 No Be (25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 1 Yes 2 No Other: ÉR/Outpatient 3 ☐ DOA 1 Inpatient 2 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 1 Natural Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) BA 10068 MO 2016 and address of person who completed cause of death (Item 23a) (Type, Print) 25500 Pt. Lookout Road ABATUNDE \bigcirc Leonardtown, MD 20650 ROGBEM 31. Date filed (Month. State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. 1 - For State Registrar 00556 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January f^{ay} 2010^{ear} Jennie We1ch 12:38 a M Elamore Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death St. Mary's Mechanicsville 27180 Oliver Lane 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, **Funeral** Country) Maryland 1 🗆 M 2 🖾 F Months Days Min (Month, Day, Year) 04/07/1922 Director 87 213-22-1419 Usual Residence of Decedent show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director ms 23a or 28a-f s must be notified 1 Yes 2 No Maryland St. Mary's Mechanicsville 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20659 USA 27180 Oliver Lane Was Deceus.
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27 is marked other than "

r traumatic event, the Med Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ R. Ridge11 Nelson Edith Dean 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t of Health If item 27 Arleen Oliver/Daughter 27180 Oliver Lane, Mechanicsville, MD 20659 other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 😾 Burial 2 □ Cremation 3 □ Removal from State Department of Important: If any injury or once. 4 Donation 5 Other (Specify) 01/05/2010 Helen, Maryland Queen of Peace 21. Signature of Funeral Service Licensee
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1 Yes 2 No Day Year Month signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown cate has been si, page 2 should b To Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 1 Yes 2 No Yes 2 N 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 1 🗌 Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify, 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) the funeral 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? s after death. 28d. Describe how injury occurred 5 Pending 1 Natural 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined To the Hospital or within 24 hours at To the Funeral D Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 4005575 1-4-10 , pme person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 7/2009

State

Jennifer Schmidt,

JANO 5

2010

31. Date filed (Month, Day, Year)

D.O.

Box 68760

P.O.

Records,

Division of Vital

ORIGINAL

40900 Merchants Lane, Leonardtown, MD 20650

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month O/ Physician/ Day 05 20/0 ATRICIA 0644 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner City, Town, or Location of Deatl 4c. County of Death ANNE ARUNDEL MEDICAL ANNAPOUS, MARYLAN ANNE ARUNDE 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral 9. Birthplace (State or Foreign South Dakota Director 134-50-0732 Yrs. March 1962 Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland 1 Tyes 2 No Queen Anne's Chester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1702 Harbor Drive 21619 United States of America 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 XNo þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify: 3 Widowed 4 Divorced Specify: Completed Caucasian 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Office Manager Auto Repair Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Marlin Ethmer White Kav Rozena Anderson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard White Son 1702 Harbor Drive, Chester, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 😾 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) cemetery, crematory or other place, Denton Cemetery 1/11/2010 Denton, Maryland 22. Name and Address of Facility Moore Funeral Home, P.A. 21. Sign ture of Juneral Service Ligens 12 South Second Street, Denton, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEVERE Physician/ ARDIOMYOPATHY disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-transi Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 🗆 Fetal death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) Day Year been signed by the sahould be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has l autopsy 2 **X** No 1 ☐ Yes 2 ☐ No Yes filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes ပ 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify, 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death Certificate: 1 Natural 28a. Date of injury (Month, Day, 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 🗌 Yes 2 🗌 No Accident A Investigation Suicide Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 only or Certifying Norse Fractioner: To the best of my knowled 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0051024 01.05.10 address of berson who completed cause of death (Item 23a) (Type, Print) ANNAPOLIS MD 21401 2001 MEDICAL 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

K2 6

DHMH 17 Rev 7/2009

		State of Maryl 1 - State Registrar		artment of F ertificate of I		Mental Hy	/gienę Reg. No.	010	00558				
Physici		1. Decedent's Name (First, Middle, Last) JAMES MAYHLON WATSON -	0			2. Date of De Month	Day	Year	3. Time of Death				
/Medio Examir		4a. Facility Name (If not institution, give street and number) CIVISTA MEDICAL	ENTER	4b. City, Town, or	Location of Dea			County of Deat					
Funeral Director			yrs. last birthday, 79 Yrs.	Months Days	If Under 24 Hrs Hours Min		rth ay, 193	9. Birt	thplace (State or Foreign untry)				
f show	tor	Usual Residence of Decedent	. City, Town or Le	ocation WALDOR	 F				10d. Inside City Limits 1 □Yes 2☒No				
a or 28a-	I Director	10e. Street and Number 47 MEADOW LANE		10f. Zip Code 206	01		10g. Citiz	en of What Co	l untry?				
I", or items 2:	by Funeral	11. Marital Status 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in Armed Forces? 1 □ Yes 2 No If Yes, Give Year or Dates:	n U.S. 13.	Was Decedent of H If Yes, specify Cuba 1 □ Yes ※ No	ispanic Origin? (In, Mexican, Pue Specify:	Specify Yes or Norto Rican, etc.)		4. Race - Ame Black, White Specify: WH	e, etc.				
per first rages i and a should be first whith rather are to death with the way year per first rages of the first and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinar must be notified at once.	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 11th College (1-4or 5+)	(Give	edent's Usual Occup e kind of work done o DO NOT use retired CTOR TRA	during most of wo f)		ANDR	d of Business/ EWS & B. AII	BARTLETT				
lental Hygirked other	To Be Co	17. Father's Name (First, Middle, Last) JAMES M. WATSON, SR.	ı			me (First, Middle JOHNS		Surname)					
alth and M 27 is mar r traumat	-	19a. Informant's Name/Relationship (Type. Print) VERA N. WATSON-SPOUSE	Town, State, 2										
nt: If item		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		tion - City or Town, State									
Departm Importa any Inju		21. Signature of Funeral Service Licensee MO-0479		2. Name and Addre RAYMOND LA PLAT	ss of Facility	AL SERV	ICE,	P.A.					
hysician and busician free private transit the private transit the private transit the private transit the private transit that the private transit the private transit transit the private transit tr	23a. Part 1. Enter the disease, or complications that haused the death. Do not inter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause leach line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):												
attending or use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of prediction of the past 12 months? 1 □ Live birth 2 □ In □ Live birth 2 □ Live birth	Fetal death 3	☐ Ectopic pregnanc	у		2	3d. Date of de Month	livery Day Year				
n signed by the aild be detached	þ	Part II. Other significant conditions contributing to death but not	resulting in the I	underlying cause giv	en in Part I.		tobacco us		o the cause of death?				
s certificate has been sirector, page 2 should I	Completed		24b. Were a prior to death?	utopsy findings available completion of cause of s 2 No									
is certifi director	o Be	25. Was case referred to medical examiner? 1 □ Yes 2 No Hospital: 1 Inpatient	2 ER/Outpatie	ent 3 DOA Oth	or:	eath (Check only Home 5 Res		☐ Other (Spe	ecify)				
within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Certification: To	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day, Yea		M 1 🗆	yat k? Yes 2 □ No	28d. Describe	how injury	occurred					
rs after de ral Directo led in by t	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Factory, office building, etc. (Specify)												
in 24 hou he Funer	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my 2 Medical Examiner: On the basis of examiner stated.	knowledge, dea mination and/or i	ath occurred at the ti investigation, in my o	me, date and pla opinion, death oc	ce, and due to th curred at the time							
with To 1	Σ	29b. Signature and title of pertifier MD MD		29c. Licens	06/16	52	0	e signed (Mon	2010				
le		30. Name and address of person who completed cause of death ATUL Kat yell MD (POST) 31. Date filed (Month, Pay, Year) 32. Registrar's S		Rd Su	ite 10,	1 Wal	dor	Md	20602				
Sta Registi		31. Date filed (Month, Pay, Year) 32. Registrar's S	ignature	0 1				,					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		•	1 - State State Registrar Certificate of Death Reg. No. 2010											
	Physicia Medio		1. Decedent's Name (First, Middle, Last) Michelle	Wi	lliams	2. Date of Death January	3. Time of Death 9:40 PM M							
	Examin		4a. Facility Name (if not institution, give street and r 6001 Mount Phillip R	oad	4b. City, Town, or Location Frederick	of Death	4c. County of Death Frederick							
	Funeral Director		5. Social Security Number $213-64-6112$ 6. Sex 1 $^{\square}$ M 2 \overline{X}	7. Age (In yrs. last birthday) 71 Yrs.	If Under 1 Year If Under 1 Months Days Hours	Min. 8. Date of Birth	9. Birthplace (State or Foreign Country) France							
	land show d at	tor	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	ocation		10d. Inside City Limits							
	Mary 28a-1 otifie	Director	MD Frederick	Fre	derick		1 ☐ Yes 2 🟋No							
	h with the ns 23a or nust be r	Funeral D	10e. Street and Number 6001 Mount Philli		10f. Zip Code 21703		Og. Citizen of What Country? United States							
9800	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	1 Never Married 2 Married 1 1 Yes,	s 2 V No	Was Decedent of Hispanic On If Yes, specify Cuban, Mexican Personal Persona		14. Race - American Indian, Black, White, etc. Specify: white							
215-0	an "nati Medica	Completed	15. Decedent's Education (Specify only highest grade complet Elementary/Seconday (0-12) College	ed) (Give	dent's Usual Occupation kind of work done during mo DO NOT use retired)	st of working	16b. Kind of Business Industry							
212	withir giene ner tha t, the		9 Conlege	h(1-4-01-3+)	omemaker		own home							
land	l be filed lental Hy rked otl tic even	To Be	17. Father's Name (First, Middle, Last) Emile Boutin			her's Name <i>(First, Middle, M</i> brielle Bai	,							
lary	should and M is ma 'aumai		19a. Informant's Name/Relationship (Type, Print)		ng Address (Street and Numb									
e, N	and 2 Health tem 27		Antoinette Flook/d	aughter 600			cederick, MD 21703							
Baltimore, Maryland 21215-0036	Page 1 Iment of tant: If i		1 N Burial 2 □ Cremation 3 □ Removal from 4 □ Donation 5 □ Other (Specify)	om State Resthave	matory or other place) en Mem.Gard	Frederick, MD								
Ball	permit Depart Impor any in		21. Signature of Funeral Service Licensee	Signature of Funeral Service Licensee MO1222 Reeney and Basford PA Funeral Hot Reeney and Basford PA Funeral Hot 106 East Church St., Frederick, la. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,										
. 54	Physician	S 19												
-	Medical Examiner		resulting in death) Due											
	ted sit	Examiner	cause. Enter Underlying Cause (Disease or iinjury	ю (от ав в солвециеное об;										
0	ificate be executed ig physician and as the burial-transif		that initiated events resulting in death) Last	to (or as a consequence of):										
8760	cate b physic the b	Medical	d											
Box 6	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Of the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/N	in the past 12 months?		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year							
P.O.	s that th gned by se detac	by Ph	Part II. Other significant conditions contributing to	o death but not resulting in the	underlying cause given in Par	t I. 23e. Did tob	acco use contribute to the cause of death?							
rds,	requires been signatures					1 Ye								
Reco	sician: The law r certificate has b irector, page 2 sl	Completed				24a. Was ar autops perform 1 \sum Yes 2	y prior to completion of cause of death?							
ta	ician: certific ector,	Be	25. Was case referred to medical examiner?											
Division of Vital Records, P.O.	To the Hospital or Attending Physician: whithin 24 hours after death. To the Funeral Director After this certific completed filled in by the funeral director,	ate: To	27. Manner of Death 1	Inpatient 2 ER/Outpatie tte of injury onth, Day, Year) 28b. Time o injury	f 28c. Injury at work?	Nursing Home 5 Reside 28d. Describe ho								
visior	I or Attending after death. Director: After in by the funer	Certificate:		lce of Injury - At home, farm, strilding, etc. (Specify)	M 1 ☐ Yes 2 ☐ reet, factory, office		reet and Number or Rural Route Number, State)							
Ö	Hospital of 24 hours at Funeral Detection illed in	Medical C	29a. Certifier 1 Certifying Physician: To th											
	To the H within 24 To the Fu complete	Me	(Check 2 Medical Examiner: On the only one) 3 Certifying Nurse Practions 29b. Signature and title of certifier			te and place, and due to the								
			Mucrelle & Cons	om, so	△ 316		anuary 4, 2010							
	4		30. Name and address of person who completed completed to the second of	ause of death (Item 23a) (Type, I	Print) W. SEVENTA	ST. FREE	ENCK ND 21701							
	Stat Registra		31. Date filed (Month, Day, Year)	/										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 20b per fh 8899 1-29-10 vt
State of Maryland / Department of Health and Mental Hygiene
1- State Amend 10b,d,e,f, 15, & 19a, per FH/Inf 6902 4/21/10 TT
Reg. No. 10 00560 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 6:00 PM sanah lexano -13-2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner timore 7. Age (In yrs. last birthday) If Unc If Under 24 Hrs Date of Birth (Month, Day, 9. Birthplace (State or Foreign Country)
S. America **Funeral** Min Months 1 **3**M 2□ F 80 Yrs. Days Hours Director Usual Residence of Decedent Pages 1 and 2 sho. Id be filed withir 72 hours after death with the Maryland nent of Health and Nental Hygiene. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show ns 23a or 28a-f sh must be notifled 1 Yes 2 No Director m1) imore 700 W. 40th Street 21211 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 210 USA Funeral 14. Race - American Indian, or items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 2 No ☐Yes 2 Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Saltimore, Maryland 21215-0036 Specify þ If Yes, Give Year or Dates: 3 ☐ Widowed 4 ☑ Divorced "natural", lac Completed 16a. Decedent's Usual Occupation is marked other than "naturaumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Health amin 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be lla 2 Item 27 is marke other traumatic Print) Ex-W 19a. Informant's Name/Relationship (Type 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WI mi) 21249 45sana Marie 20a. Method of Disposition Db. Place of Disposition (Name of Kinger Memory) (as he 20c. Location - City or Town, State Department of Himportant: If Ite any Injury or ot once. Park 3 □Removal from State 1 Burial 2 □ Cremation 1-2010 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Auch n 8728 RA Kandallstuun MI) 21183 23a. Part1. Enter my disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirating arrest shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CARDIOYASIULAR DISEASE HTHEROSCIEronic **Physician** inkour disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last requires that the death certificate be executed use as the burial-tran and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month signed by the a 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of certificate has brieger, page 2 s autopsy performe death? 1 ☐ Yes 2 No 1∐ Yes 2 No To the Hospital or Attending Physician: filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) P 1 🔲 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day Year) 27. Manger of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 Yes 2 No after death. 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3□ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 13/2010 D0054056 MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 700 WEST yoth Bult MO 21211 Sulusc 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registra JAN 15 2010

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ JANUARY 12, 2 or 10 SALVATORE ALAIMO 3:32 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death JOHNS HOPKINS BAYVIEW BALTIMORE N/ASocial Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 💢 M 2 🗆 F Months Hours Min FEB. T. 1921 MARYLAND Director 212-12-5666 88 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits filed within 72 hours after death with the Maryland Director ms 23a or 28a-f s must be notified MD N/A 1 X Yes 2 ☐ No BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3908 HUDSON STREET 21224 U.S.A. or items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🎇 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or item edical Examiner n 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 X Married 1 Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: 3 🗌 Widowed 4 🗆 Divorced Specify: WHITE Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) other than Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. LABORER NATIONAL BREWERY Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ t. Page 1 and 2 should be trent of Health and Ments trant: If item 27 is marked jury or other traumatic e should be VINCENZO ALAIMO LAURENDA CATANZARO 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BARBARA ALAIMO/ WIFE 3908 HUDSON STREET, BALTIMORE, MARYLAND 21224 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place 1 💢 Burial 2 🗌 Cremation 3 🗌 Removal from State Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) OAK LAWN CEMETERY :1/16/2010|BALTIMORE,MARYLAND 21. Signature of Funeral Service Licensee Y & ZETLER INC. FUNERAL HOME S. CONKLING STREET, BALTO., MD 21224 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Le Myoc mdin Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine it any teach, to Immedicause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Day Year 4 Pregnant 9 Unknown Pregnant at time of death Yes 2 No 1 ☐ Yes ∠ ☐ 9 ☐ Unknown After this certificate has been signed by the funeral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ♣No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No filled in by the funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certificate: To 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred (Month, Day, Year) injury 1 Natural 5 Pending Accident Investigation after death Director; 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined ε Funeral I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one) 29b. Signature and title of certifie,

State Registrar

DHMH 17 Rev 7/2009

30. Name and address of person who completed cause of

death (Item 23a) (Type, Print)

De Print)
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THERESE, ANDRYKOVITCH

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	-	For State Registrar	State of Ma	aryland .		artment of F tificate of L		•	glene. _{Reg. Nc.} 201(00562						
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Examir		4a. Facility Name (if not institution, give Hebrew Home of G		ningtor	n	4b. City, Town, or Rocky		ith	4c. County of Dea							
Funeral Director		5. Social Security Number 6. S 165-12-5322	ex 7. Ag	e (In yrs. last I 39		If Under 1 Year Months Days	If Under 24 Hr Hours Mir		th 9. B	irthplace (State or Foreign ountry) nsylvania						
and show	ro	Usual Residence of Decedent 10a. State 10b. County		10c. City, To	own or Lo	cation				10d. Inside City Limits						
e Maryl. r 28a-f notifiec	Director	Maryland Montgo	mery	Roo	ckvi1	1e			10-04	1 ☐ Yes 2 🎇 No						
with the s 23a o	Funeral	4809 Oxbow Road				2085	2		10g. Citizen of What C United St							
ire, Maryland 21215-0036 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. If mark 2 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	þ	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 🕅 Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 II If Yes, Give Year or Dates.			Vas Decedent of H f Yes, specify Cuba ☐ Yes 2 🔀 No		Specify Yes or No- rto Rican, etc.)	14. Race - Am Black, Wh Specify:							
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land be filed ental Hy ked ott	To Be	17. Father's Name (First, Middle, Last) Charles Piliero						_{ame (First, Middle,} es Maron	Maiden Surname) e							
Mary 12 should alth and M 27 is man			Ba. Informant's Name/Relationship (Type, Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Z. 4707 Topping Road, Rockville, Maryland 2													
Baltimore, Maryland 21215-0036 cernit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", o any injury or other traumatic event, the Medical Examono.		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐	Removal from State	20b. Place	etery, cren	sition (Name of natory or other place		nuary 16, 010	20c. Location - City of Silver Spring							
Baltimora permit. Page 1 a Department of P Important: If ite any injury or of		21. Signature of Funeral Service-Ligen	4 Donation 5 Other (Specify) Gate of Heaven Cemetery, 2010 Silve 1. Signature of Funeral Service Ligensee M01305 M01305 Gate of Heaven Cemetery, 2010 Silve Robert A. Pumphrey Funeral Home/Rocky 300 West Montgomery Avenue, Rockville													
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Medical Examiner		resulting in death)	a. Due to (or as	a consequence	ce of):	2RY	FAIL	URE								
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ivision of or Attending after death. Director: After in by the fune	Certificate:	2 Accident Investigatio 3 Suicide 6 Could not b 4 Homicide determined	e 28a Place of Init		e, farm, str	M 1 L	Yes 2 ☐ No	28f. Location (City or Tov	Street and Number or F vn, State)	iural Route Number,						
Division To the Hospital or Attent within 24 hours after death To the Funeral Director. completed filled in by the	Medical	(Check 2Medical Exam	iner: On the basis of e	xamination an	nd/or inves	tigation, in my opini	on, death occurre	d at the time, date a	ause(s) and manner as s and place, and due to the ne cause(s) and manner a	e cause(s) and manner stated						
Solution (29b. Signature and the of certifier Discussion 30. Name and address of person, who BACBURA KHILL	Labor	NK	I.P.	29c. Licens	e number 7 3 7 4	36	29d. Date signed (Mor	oth, Day, Year) 09,2010						
		30. Name and address of person who	completed cause of d	eath (Item 23	HUN	PLOSE R.	P. RUCK	EVILLE	, MD 2	0852						
Sta		31. Date filed (Month, Day, Year)	AVI	ar's Signature												
Registr	ar	WANT & SOLO	Chron	t. for	ale											

10-00299 -		Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.									
Darel Marcel Als		State of Maryland / Department of Health and Mental Hygiene - For State Certificate of Death	00563								
Physicia		RegIstrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death	3. Time of Death								
Medical Exami		Darel Marce Alston January 10, 2010	2215 hrs								
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 900 N. Glover Street Baltimore	IIA								
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birth	hplace (State or								
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		Usual Residence of Decedent									
ow any		10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits 1 Yes 2 No								
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th the Maryland 23a or 28a-f sho notified at once	Director	8408 Inwood Cowst. 20794 115A									
ms 23s		11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- 14. Race - Americal Armed Forces? 15. Was Decedent of Hispanic Origin? (Specify Yes or No- 15. Was Decedent of Hispanic Origin? (Specify Yes or No- 16. Was Decedent of Hispanic Origin? (Specify Yes or No- 17. Marriad Status	can Indian, Black,								
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ırs afte ural",	ò	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify: Specify: Specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Dccupation (Give kind of work done 16b. Kind of Business/li	ndustry								
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5-0036 led within 72 hours after Hygiene. other than "natural".	Completed	12 Security Protec	tion								
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E 0 - 0 - 1		George Alston - tather 8408 Inwood Ct, Jessup,	MD 20794								
Ψ – i – i – i		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or crematory or other place)	Town, State								
드스워드는		4 Donation/5 Other Specify/ 24 Signature of Funeral Service Censee 22. Name and Address of Facility 22. Name and Address of Facility	102e								
Balti permit. Departn Import		22. Name and Address of Faiglity Howell Function 10220 Guilford Rd 1855	MI SUGUL								
Physician		23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.	Approximate Interval Between Onset and								
/Medical Examiner		Immediate Cause (Final disease a. Multiple Gunshot Wounds	Death								
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of V g Phys fter thi	라	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred	Scerie								
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Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certification of the Puneral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as the page 2 should be detached for use as the page 2 should be detached for use as the page 2 should be detached for use as the page 2 should be detached for use as the page 2 should be detached for use as the page 2 should be detached for use as the page 2 should be detached for use as the page 2 should be detached for use as the page 2 should be detached for use as the page 2 should be detached for use as the page 2 should be detached for use as the page 2 should be detached for use as the page 3.	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the									
To To Con	ğ.	and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Mon	th, Day, Year)								
		Theodon W. King Tr. m.). O.C.M.E. OGME January 11, 2010									
2		30. Name and address of person who completed duise of death (Item 23a) Theodore M. King, Jr. M.D. Assistant Medical Examinar. 111 Popp Street Raltimore, MD 21201									
,	3/0	Theodore M. King, Jr., MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date_filed (Month_Day, Year) 32. Registrar's Signature									
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			For State	State of M	aryland / Dep	artment of F ertificate of			giene 2010	00564
			Registrar Decedent's Name (First, Mide	dle, Last)				2. Date of Dea	ath	3. Time of Death
Я	Physici		Louise Lamie I	Bridges				Month January	Day Year 7 8, 2010	2:20 P M
Ç-	/Medio		4a. Facility Name (If not instituti)	4b. City, Town, o	r Location of Death		4c. County of Death	
			Sanctuary @ Ho	oly Cross			sville		Montgomer	#
	Funeral		5. Social Security Number	6. Sex 7. Ag	ge (In yrs. last birthday Yrs.	Months Days	If Under 24 Hrs. Hours Min.	(Month, Da	y, Year) Cou	place (State or Foreign intry)
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	and		10a. State 10b. Coun	y	10c. City, Town or L	ocation				10d. Inside City Limits
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	r 28a	irec	10e. Street and Number	<u>, </u>		10f. Zip Code			10g. Citizen of What Cor	intry?
	th wit 23a o ist be	alD	3415 Greencast	le Road		20866	5		U.S.A.	
	ems er m	Iner	11. Marital Status	12. Was Decedent Armed Forces	t Ever in U.S. 13	. Was Decedent of H If Yes, specify Cub	lispanic Origin? (Sp an, Mexican, Puert	pecify Yes or No o Rican, etc.)	- 14. Race - Amer Black, White	
36	or It	y Fu	1 ☐ Never Married 2 💢 Ma 3 ☐ Widowed 4 ☐ Divorce	If Yes, Give	·	1 ☐ Yes 2 🔀 No	Specify:		Specify:	•
21215-0036	filed within 72 hours after death with the Maryland Hygiene. uther than "natural", or Items 23a or 28a-f show ent, the Medical Examiner must be notified at	Completed by Funeral Director		Year or Dates:	16a. Dec	edent's Usual Occup	oation		16b. Kind of Business/I	ite ndustry
5	in 72 n "na Medic	plet	(Specify only high Elementary/Secondary (0-12)	est grade completed)	(Giv	e kind of work done DO NOT use retire	during most of wor d)	king		•
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br	e filed al Hyg othe vent,	Be	17. Father's Name (First, Middle	e, Last)			18. Mother's Nam	ne (First, Middle,	, Maiden Surname)	
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lar	2 sho		19a. Informant's Name/Relation	. = ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' '					er, City or Town, State, Z	ip Code)
	l and lealth im 27 ther tr		Rita Stewart 20a. Method of Disposition	(Daughter)	20b. Place of Disp	Barkwood	i Ct., Je	SSup, MI	20/94 20c. Location - City or	Town State
סנ	ages nt of th		1 X Burial 2 ☐ Cremation	3 □Removal from State	cemetery, cr	ematory or other pla	عددا		,	
Baltimore,	permit. Pages 1 Department of H Important: If Ite any Injury or of		4 □ Donation 5 □ Other 21. Signature of Funeral Service	//		h Cemeter		/2010	Saltville,	VA
Ba	permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 is any Injury or other trau	Ų,	Dennis	Telloneu	v		in St.,	Saltvill	Le, VA 24370	
				or complications that cause st only one cause on each	line.		400-200-2	or respiratory a	rrest,	Approximate Interval Between Onset and Death
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Sio	Attending r death. ector: After	catic	2 Accident invest	stigation]Yes 2□No			75
Division or	or At fifer d Olrect in by	ŧ		inad Zoe, Flace UI II	njury - At home, farm, s etc. (Specify)	street, factory, office		28t. Location (City or To	Street and Number or Ri wn, State)	iral Houte Number,
	Hospital or 4 hours afte Funeral Dir tely filled in I	al Ce		ying Physician: To the bes						
	To the Hospital or Attendir within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical Certification:	(Check only 2 Medic one) 29b. Signature and title of certi	al Examiner: On the basis and manners	hotets					
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			30. Name and address of person	on who completed course of	dooth (Item 22a) (Turn	Print)	06782		1-8-10	
			Teiseen fi	nagyi	2835 Sn	rith AV	e, Suite	203	Balleniere	MD.
	St Regist	ate	31. Date filed (Month, Day, Ye.	15 2010 ^{2. Regis}	rar's Signature	parket			29d. Date signed (Mont 1 - B - 10 Ballimire	

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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

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	1- For State Registrar				Certific	ate of	Death				Reg. No		IU	0000	U
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			on, give street and no lospital Center	umber)		4	b. City, Town, c Clinton	r Location	of Death		- 1	c. County o Prince G			
	5. Social Securi		6. Sex	7. Age (In y	rs last hir	hday)	If Under 1 Ye	ar I If Unde	er 24Hrs.	8 Date of F				hplace (State or	
Funeral Director			1 X M 2 F	58	10, 100, 511		Months Day			1			Foreign	n Washingto	on
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the Maryland a or 28a-f show any tiffed at once.	10e. Street and						10f. Zip Code				10g. Cit	tizen of Wh	at Coun	try?	
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11215-0036 Id be filed within 72 hours after death with the Maryland Mental Hygiene. marked other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at once. O Re Completed by Ermaral Director	11. Marital State	us arried 2 N		cedent Ever	n U.S.		Decedent of H				10-	14. Race White		can Indian, Black,	
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5-0036 ed within 72 hour sygiene. other than "natu the Medical Exar	Elementary/S	Secondary (0-12)					st of working life				,,,,,			iddoxy	
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once To Re Completed by Finneral Director	20a. Method of		Sister	2			Washing ion (Name of co			20744 Date	20c.	Location -	City or "	Town, State	_
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Itim it. Pa rtmen ortant	4 Dorjation	Dorfation 5 Other Specify: Gardens 20								110 Strasburg, VA					_
Balt permit Depart Impor	Xac	1. Signsfure of Funeral Service Licensee 22. Name and Address of Facility Stover Funeral Horocompany, 177 N. Holliday St., Str.)
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Division of Vital Records, P.O. tal or attending Physician: The law requires that the ray after death. Tal Director: After this certificate has been signed by led in by the funeral director, page 2 should be deach by the funeral director, page 2 should be deach by Perfification: To Be Completed by P										1 🗌 Y	es 2	/ No 3 □	Proba	ably 4 Unknown	
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ijon ttendi death. ttor: t the fi	1 Natural 2 X Acciden	5 Pen	ding estigation 12/29	9/2009	7:0	7 pm	1	Yes 2 X	No ac	cident	al gi	unshot	Wou	nd past	
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Di Di hours a nneral I y filled		le	(0,000.1)	Dack											-
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transitication: To Be Completed by Physician/Medical Establication:	(Check only one) 2		hysician: To the be aminer:On the basis	of examination											
To the within To the complete t	29b Signature	and title of certific	er and manner s	stated	24		29c. Licen	se number			29d.	Date signe	d (Mon	th, Day, Year)	-
	3/1	50/1	1/00	14	950		O.C.	M.E.			Jan	uary 7, 2	2010		
	30. Name and a	ddress of persor	who completed cau	se of death (Item 23a)										\dashv
		eedn MD JD		edical Exa	miner	111 Pe	enn Street, I	Baltimore	e, MD 2	1201					
State	31. Date filed (N	nonth (A)	5 2010 32 R	egistrar's Sig	nature	1									
Registra		1. Date filed (Month) (24) 5 2010 32 Registrar's Signature A. Jack													
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DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 00566 Certificate of Death Rea. No. I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2010 Month **Physician** Day 1551 Jan 11 Alexandra Nicole Beaulieu /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore University of
5. Social Security Number Mayland Medical Center If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex **Funeral** 7. Age (In vrs. last birthday) 1 M 2 X F Days Director 11/05/1991 595–17–6576 Florida Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10a State 10d. Inside City Limits 7 is marked other than "natural", or thems 23a or 28a-f show traumatic event, the Medical Exercites and by notified at Director 1 ☐ Yes 2 X No Baltimore Monkton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 17403 Troyer Road Funeral 21111 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 ☐ Married 1 ☐ Yes 2 🕱 No Specify: <u>م</u> Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within " ment of Health and Mental Hygiene. ant: If Item 27 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) High School 11 Student 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Unknown Linda Michelle Beaulieu 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17403 Troyer Road - Monkton, permit. Pages 1 and Department of Healt Important: If Item 2: any injury or other i injury or other <u>Linda M. Beaulieu (mother)</u> 21111 Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) St. Paul's Luth.Cem. 01/15/2010 Kingsville, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 6 11750 Belair Road - Kingsville, Maryland assaln 21087 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** Intracerebra /Medical Due to (or es a consequence of): Examiner 15 days Aveurysm Se que n'idly let auditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): physician and the burial-transit Due to (or as a consequence of): Physician/Medical been signed by the attending p should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Wes decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☒ No 23d. Date of delivery 3 Ectopic pregnency Month Year 5 Other (specify) 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? s certificate has the irector, page 2 standard 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 K Natural Injury 5 Pending after death. 1 ☐Yes 2 ☐No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a the Hospitai 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only To the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2010 11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 1/2001

ear

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

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Greene St.

Bultimore.

21201

32. Registrar's Signature

Condell

M.

Kenneth

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Marie Barefoot $\underline{A}^{\mathsf{M}}$ 5:00 2010 Jan. Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Suburban Hospital Bethesda Montgomery 8. Date of Birth (Month, Day, April 26 9. Birthplace (State or Foreign Country) Pennsylvania Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Days Months Hours 1 □ M 2 □ F 69 Director 196-30-4079 Yrs Apri] Usual Residence of Decedent "natural", or items 23a or 28a-f shov edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 1 ☐ Yes 2 🗓 No MD Silver Spring Montgomery 10e. Street and Number 10g. Citizen of What Country? Funeral United States 10211 Calumet Dr. 20901 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify. Specify: 3 XWidowed 4 ☐ Divorced Year or Dates other than "natura vent, the Medical E 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Mental Hygiene. Homemaker Own Home 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) item 27 is marked ၉ Mary Walk Samue1 Klapach 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 10211 Calumet Dr., Silver Spirng, MD 20901 Gwendolyn Shinko / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of IImportant: If ite
any injury or ot 1

Burial 2

Cremation 3

Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 1/14/2010 21. Signature of Funeral Service-ticensee ^{22, Name and Address of Facility}
Rapp Funeral and Cremation Services
933 Gist Ave., Silver Spring, MD M00382 20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph_sician/ Metabletic 2 MONTHS disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Elise or Underling Cause (Disease or iinjury that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death signed by the a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes The law requires 2 No 3 Probably 4 Unknown cate has been signated by page 2 should b Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No this certificate 1 Yes 2 No the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) **Division of Vital** examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **N**0 Certificate: To ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manual of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred $5 \square$ Pending Natural Accident Investigation 6 Could not be 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours af

To the Funeral Di

completed filled in Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
☐ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 3 29c. License number 29b. Signatur 29d. Date signed (Month, Day, Year) 2010 D60117 -13 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8600 Old Grewsetown Rd PARK D.

Registrar

State

31. Date filed (Month, Day, Year)

NEIG

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. Z Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** Baker C. 2010 Raymond January /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner oseda mare If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day,) October 6, Birthplace (State or Foreign Country) 7. Age (In yrs. ast birthday 5. Social Security Number **Funeral** Maryland Months Hours Days 1 XM 2□ F 67 215-40-5469 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mertal Hygiens. In Department of Health and Mertal Hygiens. In Department if Health and Mertal Hygiens "Hatural", or Items 23a or 28a-f show Important: It flem 7 is a marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, I'm Medical Examinations is be mailted at 1 ☐ Yes 2 X No Director Dundalk Maryland Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21222 6544 Riverview Avenue Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 XYes 2 ☐ If Yes, Give Year or Dates: 2 No 1 Never Married 2 Married Kay Mond Laker Baltimore, Maryland 21215-0036 White 1 □Yes 2 🗖 No Specify. Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Food 11 years Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Ann Bowers John Henry Baker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6544 Riverview Avenue, Dundalk, Maryland 21222 Carol Lee Baker wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) January 13, 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Bayview Crematory Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 2010 Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Maryland 21222 Signature of Funeral Service Licenses Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. To not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician TION disease or condition resulting in death) /Medical Due o (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-transit law requires that the death certificate be executed and Due to (or as a consequence of): attending physician for use as the buria P.O. Box 68760 Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 9 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy Hospital or Attending Physician: The certificate 1 XYes 2 ☐No Division of Vital 25. Was case referred to medica examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Main Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Certification: To funeral (27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐Yes 2 ☐ No 24 hours after death. Funeral Director: A 2 Accident filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. To the I 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier NGUYEN

State Registrar 30. Name and address of person,

DHMH 17 Rev 1/2001

uare

Baltimore, MD. 21237

23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 00569 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Beaudet C. 3:30 2010 Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner Square HOSPITA Kosedal Baltimore 9. Birthplace (State or Foreign . Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days Min. Months Hours 1 🗆 M 2 💢 F 218-18-4349 87 Director October Usual Residence of Decedent 10b. County 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown injury or other traumatic event, the Medical Examiner must be notified at enes. 10a, State 10c. City, Town or Location Director 1 XYes 2 No N/A Baltimore Maryland 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral USA 21230 1450 Patapsco Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11 Marital Status Black, White, etc. þ 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 X No Specify: White 3 XWidowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Housewife Own Home 8 years Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Julia Chick Stephan Chornyei 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5530 Apperson Road, White Marsh, Maryland Henry T. Beaudet Jr. son Baltimore, I 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State January 1
Burial 2
Cremation 3
Removal from State Baltimore, Maryland 15, 2010 Bayview Crematory 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses Conneily Fufferal Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 21222 23a. Part 1. Enter the disease, promplications that caused the death op not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician yponatremia disease or condition resulting in death) Medical Due to (or as a consequence of): Heart failure Examiner estive Sequentially list conditions. any, leading to infinediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Dementia de th certificate be executed physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 ttending por use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Veat Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown Hospital or Attending Physician; The law requires that the been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has I page 2 s autopsy performed? Yes 2 No 1 Yes 2 No this certificate director, Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 🗹 No ၉ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Accident
Suicide Investigation by the 1 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined thin 24 hours after the Funeral Directory the Funeral Directory in the Funeral Directory in the filled in the fill Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one)

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

SYVARE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

F-RANKLIN

et

DRZVE

KOTTARATHILL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar			State of	t Mar	yland		artmen rtificate			ind Me	ental Hy	glen Reg. No	.201	0	00570
	Physicia	an	1. Decedent's Name (First, Middle, Last) 2. Date of Death												ay Yea	ar	3. Time of Death	
10	/Medic	Margaret Frances Bosley											Januar	1, 2010 9:20 P M				
	Examin	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death															
1	Farmer I		Greates 5. Social Security N	imore 6. Sex	e Medical Center 7. Age (In yrs. last birt							24 Hrs. 8. Date of Month,		Birth Baltimon			lace (State or Foreign try)	
	Funeral Director		220-36-91			м 2⊠ F	3	68		Months	Days	Hours	Min.	uly 4	ay, Year, 194			land
			Usual Residence o														Od. Inside City Limits	
	arylan show ed at	<u>_</u>	10a. State	10b. Count				,	Town or Lo	cation							10	1 □Yes 2X No
	he Ma 28a-f lotifie	Director	Maryland 10e. Street and Nu		imore	:		Carn	ey	10f. Zip	Code			1	10g C	itizen of What	Count	
	with a sa or		9531 Bur		'Δ						234				-	S.A.	Courn	.,,.
	death ms 2; mus	Funeral	11. Marital Status	2011 110		2. Was Dece	edent Ev	er in U.S	. 13.			spanic Orig	jin? (Spec	cify Yes or No lican, etc.)		14. Race - A		
-0036	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f show ent, it a Medical Examiner must be notified at	by	1 ☐ Never Marr 3 ☐ Widowed			Armed Fo 1 □Yes If Yes, Giv Year or D	ve		1	ir Yes, spec 1 ∐Yes 2		n, Mexican, Specify:	, Puerto H	ican, etc.)		Black, W		
200	72 ho	Completed	(Spe	15. Decede	nt's Educa	ation		-77	16a. Dece	dent's Usua	al Occupa	ation Juring most	of working	a	16b. h	Kind of Busine	ss/Ind	ustry
7 7	ithin 7 ne. han "1	mple	Elementary/Seco		grade t	College (1	-4or 5+)				e retired)	luring most)		9				
25	led w lygiel her tl		17 Father's Name	(Eirot Middle	\				Homen	aker_		18 Mother	r'e Nama	/First Middle		n Home		
and	should be nd Mental marked o	To Be	17. Father's Name (First, Middle, Last) Geoffrey McElfish Mary Elise Maquire															
<u>₹</u>			19a. Informant's N			e. Print)			19b. Mailir	na Address	(Street a					or Town, Stat	e, Zip	Code)
$\frac{1}{2}$			Mr. Ellw				se)									nd 2123		,
$\sqrt{5}$	s 1 ar of Hea ltern othe		20a. Method of Dis	sposition			<u>/</u>	20b. Pla	ace of Dispo	sition (Nam	ne of ther place	e) T	Da	ite		ocation - City		wn, State
28	Page nent c int: If		1 ☐ Burial 2] 4 ☐ Donation	Cremation 5 ☐ Other (3 □Rei Specify)	moval from	State	Evar	ace of Dispo metery, crei IS Fun Bel	eral	Chap	œl ¦Ja	an. 1		For	rest Hi	11.	, Maryland
COS Baltimore,	permit. Pages 1 and 2 s Department of Health ar Important: If Item 27 is any injury or other trau once.		21. Signature of			· Ix	1		. 22	Name an	d Addres	s of Facility	/					
<u> </u>	9 9 E E 9		Evans Funeral Chapel & Cremation Services Parkvi 8800 Harford Road, Parkville, Maryland 21234												21234			
			23a. Parl 1. Enter shock, or he	in disease, d ar failure. Lis	or complica st only one	ations that c	aused th	ne death.	Do not en	ter the mod	e of dying	g, such as	cardiac or	respiratory a	arrest,			Approximate Interval Between Onset and Death
	Physician		Immediate Cause disease or condition	(Final on	a.		4E	SPIY	VATOR	24 +	AIL	LUR	E					Onset and Death
	/Medical Examiner		resulting in death)			Due to	(or as a	conseque	ence of):	-								
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2	uted I Insit	Examiner	Sequentially list con it any, leading to in cause. Enter Unde Cause (Disease or	erlying - r injury	<	Duc 13 ((3) 40 4	oonooqui	onoc cry.									
Mi	be executed sician and burial-transit	Exa	that initiated event resulting in death)	s Last	c.	Due to ((or as a	conseque	ence of):								+	
68760,	cate be ohysicia the bur	ledical			d.													
	rtifica ng ph as th	Nedi	IF FEMALE:												- 1			
Вох	leath certifi attending for use as	Physician/M	23b. Was deceder	nt pregnant	230	c. If yes, out		f pregnan		☐ Ectopic p	regnancy	y			4	23d. Date of Month		ery Day Year
О.	at the dea by the at tached fo	sici	in the past 12	ZNo		4 ☐ Pregi 9 ☐ Unkn	nant at t			Other (sp		,				WOTH		Day rear
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Re	The lay cate has page 2	Completed	- 101	WYIIC	OVA	ZIVOL	רטוג		/ P-10P1	1	PI	JUME	<u> </u>	auto	opsy ormed? 2 N	prior	to con	mpletion of cause of
tal	ician; The certificate ector, pag		25. Was case refe	rred to medic	al							26 Place	of Death			lo 1 1 1	/es	2 □No
>	Physician; r this certific ral director, p	o Be	25. Was case referred to medical examiner? 1 Yes 2 No											v)				
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ioi	Attendir death. ctor: At y the fu	atic	1 Natural 2 Accident		tigation					М	1 🗆 Y	Yes 2□N	No					
Division of Vital Records,	or Att	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 ∏Could deter	mined	28e. Place buildi	of Injur	y - At hor (Specify)	ne, farm, str)	eet, factory	, office		2	8f. Location City or To	(Street a wn, Sta	and Number o te)	r Rurai	d Route Number,
	pital ours a eral D		29a. Certifier	1 Coutifu	ina Physic	nian. To the	- boot of	mu knou	ulodgo dost	h coourrad	at the tim	no dato an	d place a	and due to th	0.031160	(s) and manne	or ac c	tated
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	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Me	29b. Signature and	d title of certifi	ier	(290	. License	e number	2 (29d. D	ate signed (M	onth, I	Day, Year)
			·m	7,5/	111	rol	1/2	M	10		1)-	44	720	5	0	1-12	2-;	2010
	5		30. Name and add	lress of perso	n who com	npleted caus	se of de	th (Item	23a) (Type,	Print)			,	4.4	0.1	550		21204
	Û		Mite	chell	L 50	chw	Cler	121	11)	5535	N	Ch	arle	ost.	He:	100	W	on Mp
	Sta Registr	_	31. Date filed (Mor	nth, Day Year	152	010 ^{32. R}	estrar	's Signati	ure A.	park								

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Registrar

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AMEND ITEM#22perFH, G899, 1/4/2010, WSI
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 7 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3:45 PM Physician Tanuary 2010 OUIS /Medical 4b. City, Town, or Location of Death 4c. County of Death n, give street arid number) 4a. Facility Name (If not institut **Examiner** Agres Hospital Bultimore Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Date of Birth Month, Day, 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 1 M 2□ F 86 Yrs. MD 212-20-2975 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a, State ir than "natural", or Items 23a or 28a-f show the Medical Examinar must be notified at 1 Yes 2 No altimore Completed by Funeral Director MM 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21229 Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status rmed Forces? ☑ res 2 ☐ No Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: Maryland 21215-0036 If Yes, Give Year or Dates: 1943 Specify: Black 3 ₩idowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygie Important: If item 27 is marked other til any injury or other traumatic event, I'm once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) UNK Be imm5 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type, Print) Grantley Sal timory MD 21239 20c. Location - City or Town, State Baltimore, 20b. Place of Disposition (Name of permetery, crematory or other place) 20a. Method of Disposition Owings Mills MD 1 Burial 2 ☐ Cremation 3 ☐ Removal from State arrison forest 9-2010 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Kandallston, MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Jai line shock, or heart failure. List only one cause on each line. Onset and Death

2 Court respiratory Immediate Cause (Final disease or condition resulting in death) Hypodic **Physician** /Medical Due to (or as a consequence of) encephal Examiner netabolic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine rnown orice death certificate be executed physician and the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) ed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? this certificate 1 ☐ Yes 24100 the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Division of 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death eral Director: After filled in by the funer 5 ☐ Pending investigation Injury 1 Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 - Homicide within 24 hours a

To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 6 9 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier \mathbf{c} \mathbf{m} Hlowing January, 11, 2010 30. Name and address of person who completed cause of death (Item 23a), Type, Print)
HLAING TINT, 900 Cator Averue , Baltimore, MD 32. Registrar's Signature 31. Date filed (Month, Day, JAN 1 4 Year) 2010 State arker Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
AMEND ITEM#1,#23e, perPHYS G899, 1/19/2010 WS
State of Maryland / Department of Health and Mental Hygien 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First Middle, Last) John 2. Date of Death 3. Time of Death **Batts** Month Day Year **Physician** 01:15 AM 0 09 10 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimar & If Under 24 Hrs. N mvesity of Moyled Medical Centr Date of Birth (Manth, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 216-54-365 7. Age (In yrs. last birthday) **Funeral** Year) 1 **X**M 2□ F Months Hours Days Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examinar must be routified at once. 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a, State MD Randalistown 1 □Yes 2 No Baltimore Be Completed by Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21133 4008 Winlee Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: Specify: Back 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Bethlehem Steel Steel Worker 12th grade -vears 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Gladus Clark Samuel ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Valene Batts 4008 Winter Road Randallstown MD 21133 /Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Owingo Mills, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Vauy fon C. Greene Funeral SICS 21. Signature of Funeral Service Licenses Randallotown MD 21/33 oad Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart dailure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) 1 Schemiz Cordism /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Physician/Medical Examiner To the Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 □Yes 2 □No s been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown hu nestersia 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an After this certificate has tuneral director, page 2 s 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Medical Certification: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1☐Inpatient 2☐ER/Outpatient 3☐DOA 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1. Natural 5 ☐ Pending investigation Injury within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier t 🚾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 1/9/10 NP1:1831324221 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 S. Green Street 32. Registrar's Signature Bellmore MD 2120 Me MD ansse 31. Date filed (Month, Day, Year) State 4 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ OI Month 2010 05:00 Crawford Brown Sr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Towson Baltimore Gilchrist Hospice 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Year) 3 <u>2</u> Country) VA **X** □ M 2 □ F Days Hours Min. Month, Pay. Director 212-30-7034 Usual Residence of Decedent 23a or 28a-f show ist be notified at 10a. State 10b. County 10c, City, Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 XYes 2 No Baltimore MD NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21215 3800 West Belverdere Ave U.S.A. or items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 2 should be filed within 72 hours after deati th and Mental Hygiene. 27 is marked other than "natural", or iten traumatic event, the Medical Examiner r 14. Race - American Indian Armed Forces?

1 Yes X No
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: Black 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 10th grade na Welder Shipyard Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Unknown Unknown permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 603 Edinshall Trail, Belair, Md 21014 Darnell Brown-Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) On-Site 1/20/10 Baltimore, Md . Sign dure 🚰 Funeral Service Licensee 22. Name and Address of Facility
March F/H West
4300 Wabash Ave, 21215 Baltimore, 23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Imme rate Cause (Final Physician Acule disez e or condition ulting in death) weeks Medical Medica. Examiner Due to (or as a consequence of) monie Sequentially list conditions Examine if any, leading to immediate Cause (Disease or iinjury Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Dav Vear 4 Pregnant 9 Unknown Pregnant at time of death signed by the a Id be detached for g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? Yes 2 N after death.

Director: After this certificate 2 🗆 No 1 🗌 Yes Yes 25. Was case referred to medical filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Certificate: To 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) within 24 hours a To the Funeral C To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) R149194 ma CRNP 12,2010 January 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 701 Challes

Registrar DHMH 17 Rev 7/2009

State

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32. Registrar'

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2/204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiener Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 10:00P Willie J. Bishop Janaurv Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Balto. Nottingham 9454 Seven Courts Drive 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year I If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 □ F Days Min. Months Hours March Day 5 and 918 F9%Tida 91 Director 577-28-2612 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10d. Inside City Limits death with the Maryland Director Md. Balto. Nottingham 1 ☐ Yes 2 XNo 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral USA 9454 Seven Courts Drive 21236 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates.1936-1940 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, , or Black, White, etc 1 Never Married 2 X Married ģ Maryland 21215-0036 1 ☐ Yes 2 No White Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life. DO NOT use retired) during most of working e 1 and 2 should be filed within 72 to Health and Mental Hygiene. If item 27 is marked other than "ror other traumatic event, the Med Elementary/Seconday (0-12) College (1-4 or 5+) 12 Owner/OPerator Service Station Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Jacob A. Bishop Anna E. Bell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 shart of Health a Ollie J. Bishop 9454 Sveen Courts Drive Nottingham, Md. 21236 spouse Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or ott 20c. Location - City or Town, State cemetery, cremato Cedar Hill 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 1-14-2010 Suitland, Md 4 Donation 5 Other (Specify) 21. Signatur 22. Name and Address of Facility Schimunek Funeral Belair Rd Nottingham, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) a consequence of Examiner Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Exami executed Cause (Disease or iinjury that initiated events and Due to (or as a consequence of): resulting in death) Last the attending physician the for use as the burial Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death 2 🗌 No P.O. ģ s been signed the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 \Boxed Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 XNO Other: 4 Nursing Home 5 Residence 6 Other (Specify ၉ Ne roop.
Jin 24 hours after deau..
the Funeral Director; After this of 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work' 1 🗌 Yes 2 🗆 No 2 Accident
3 Suicide
4 Homicide M Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 🕰 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 1-12-2010

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

4 2010

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) is delphia RD, Suite 300 BACTO MD KEVIN Schendel MD 9114 Philadelphia RD, Suite 300 BACTO MD 21237

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MenthUAR Pay 11. John Edwin Bauer 10:25M 171 Medical 4a. Facility Name (if not institution, give street and number)
Saint Joseph Medical Center **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore OWSOR Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Aug 28 1926 9. Birthplace (State or Foreign **Funeral** Months Days Min. 1 XM 2 - F Hours I<u>ndiana</u> 83 Director 308-22-5324 Usual Residence of Decedent shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director Baltimore Timonium 1 🗌 Yes 2 💢 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 33 E. Timonium Rd. 21093 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 Yo Specify: Completed Specify. 3 Widowed 4 Divorced white Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 n/a <u>Electrician</u> Commercial Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and 2 should be file Health and Mental and Mental Urban Bauer other traumatic Lillian Acker permit. Page 1 and 2 st...
Department of Health an...
Important: If item 27 is m. any injury or other...
Once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Virginia L. Bauer/wife 33 E. Timonium Rd., Timonium, MD 21093 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1/15/10 1 X Burial 2 Cremation 3 Removal from State Donation 5 Other (Specify) Dulaney Valley Memorial Gardens Timonium, MD Signature of Puneral Service Un 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley, 10 W. Padoria Rd., Limonium, MD 21093 W. Ctary 4Bryan 23a. Part 1. Ent if the isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or neart fillure. List only one cause on each line. Approximate Interval Between
Onset and Death Immediate Cau of inal Physician/ CONGESTIVE HEART FAILURE disease or condition Medical resulting in death) Examiner Due to (or as a consequence of) 1 YEAR VALVULAR HEART DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Physician/Medical Examiner Due to (or as a consequence of) burial-tran Due to (or as a consequence of): resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed FAILURE RENAL 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe 1 Tes 25. Was case referred to medical 8 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify 2 No ٥ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of Certificate: 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending in 24 hours after death.
The Funeral Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of To the within 2 only one) y knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title 29d. Date signed (Month, Day, Year) 29c. License number D31189 10 0+ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MININSOHN, 7601 OSLER DRIVE TOWSON, MARYLAND 21204 MICHAEL M. D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar A. parla

DHMH 17 Rev 7/2009

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AMEND ITEMS 9 10g 14 PER C/O G 965 7-23-15 Vt
State of Maryland / Department of Health and Mental Hygiene

ED BY COUNT ORDER Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January 11, 2010 Рм 6:10 Babina Bharati Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Silver Spring Holy Cross Hospital Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 1 🗆 M 2 🔀 F Month, Day, November 7 ^{'ear)}1978 India Director 212-85-2570 31 Nepal Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits the Medical Examiner must be notified at Director 1 Yes 2 No Maryland Montgomery Montgomery Village 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò Funeral or items 23a 9412 Vineyard Haven Drive 20886 India Nepa1 death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 🖾 No Black, White, etc. Nepali 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 hours after 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates SpecifyAsian-Indian "natural", 3 Divorced 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me College (1-4 or 5+) Elementary/Seconday (0-12) 4 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Prem Kc Ganga Gurung 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20886 Sujay Bharati/Husband 9412 Vineyard Haven Dr., Montgomery Village, MD 20b. Place of Disposition (Name of cemetery, crematory or other place)
Montgomery
Crematorium, Inc. 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Jan 14, 2010 Bethesda, Maryland 21. Signatura of Funeral Solide Licensee Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. M01530 7557 Wisconsin Avenue, Bethesda, Maryland 20814 aron part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 49 Hours Immediate Cause (Final Priysician, Disseminated Intravascular Coagulation disease or condition reculting in death) Medical Due to (or as a consequence of): Examiner 49 Hours Amniotic Pulmonary Embulos Se pentially list conditions if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury 49 Hours certificate be executed Multiple Organ Failure sician and burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Physician: The law requires that the death Month Day 4 Pregnant at time of death 9 Unknown signed by the a d be detached t January 9, 2010 Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hypovolemic Shock 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed has been sig ye 2 should b 24b. Were autopsy findings available prior to completion of cause of Post Partum Hemorrhage 24a. Was an autopsy performed?

1 Yes 2 X No page death? certificate 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 X Yes 2 ☐ No မ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred the Hospital or Attending 1 XNatural iniury work? 1 🗌 Yes 2 🗌 No 5 Pending death. 2 Accident
3 Suicide Investigation within 24 hours after deatl

To the Funeral Director.,
completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 □ only one) 29b. Signature and ti 29c. License number 29d. Date signed (Month, Day, Year) D43863 January 11, 2010 person who completed cause of death (Item 23a) (Type, Print) 30. Name and addr 7411 Riggs Road #200, Hyattsville, Maryland 20783 James, M.D. Evita 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 4 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		•	For State of Ma State Registrar	ryland / Depa <i>Cer</i>	rtment of He ctificate of D			iene 93. No. 20	0	00577
	Physicia	an.	1. Decedent's Name (First, Middle, Last)				Date of Death Month		ear	3. Time of Death
-	/Medic		Louis Karl Brathwaite				January		10	1433 ^M
	Examin	er	4a. Facility Name (If not institution, give street and number) Laurel Regional Hospital		4b. City, Town, or I Laurel	ocation of Death		4c. County of Prince		cae
	Funeral			(In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	-1	. Birthpl	ace (State or Foreign
	Director		207~14-5814 1X M 2□F	82 Yrs.	Months Days	Hours Min.	(Month, Day, March 9	,1927	Coun	NY
	put w		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	cation				10	d. Inside City Limits
	// Aryla	or	,	Burtonsvil						1 ☐ Yes 2 🖾 No
	the N	Director	10e. Street and Number	Jul Colls VII	10f. Zip Code		1	0g. Citizen of Wh	at Count	ry?
	h with		4307 Leatherwood Terrace		20866			USA		
	r deal	Funeral	11. Marital Status 12. Was Decedent Every Armed Forces?		Was Decedent of His f Yes, specify Cubar	spanic Origin? (Spe n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Black,	America White, e	
36	be filed within 72 hours after death with the Maryland tial Hygiene. do other than "natural", or items 23a or 28a-f show event, the Madical Eventher.	by F	1 Never Married 2 Married 1 Tes 2 No 1 If Yes, Give 3 Widowed 4 Divorced Year or Dates:)	1⊡Yes 2 ¥⊡ No	Specify:		Specify:	Blac	ck
21215-0036	2 hour	ted t	15. Decedent's Education	16a. Deced	dent's Usual Occupa	tion		l 16b. Kind of Busi	ness/Ind	ustry
215	thin 72 e. an "n	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+	life. L	kind of work done di DO NOT use retired)			C		
2	ed wil lygien ner th it, the	Con		Compu	ter Scien	TIST 		Governme	ent	
Maryland	l be fil intal ⊦ ed otl	Be	17. Father's Name (First, Middle, Last) Louis Carl Brathwaite			Dorrit N				
Z	should nd Me mark imark	우	19a. Informant's Name/Relationship (Type. Print)	19b. Mailir	ng Address (Street a	nd Number or Rura	al Route Number	City or Town, Si	ate, Zip	Code)
×	alth a 27 is 27 is er trau		Khalid K. Brathwaite/ Son	4307	Leatherw	ood Terra	ace, Bur	tonsvill	.e, I	4D 20866
altimore,	es 1 a of He fitem		20a. Method of Disposition ★★★Burial 2 ☐ Cremation 3 ☐ Removal from State	20b. Place of Dispo cemetery, cren	sition (Name of natory or other place)ate	20c. Location - C	ty or To	wn, State
Ĭ	Pag tment tant: I		4 □ Donation 5 □ Other (Specify)	Burtonsvi		Cem. 2	2010 B	urtonsvi		
Bail	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Exerting 1 was be notified at once.		21. Signature of Funeral Service Licensee A Key Skiles MO:		2. Name and Address 13 Talbot					, P.A.
			23a. Pagri. Enter the disease, or complications that caused t shock, or heart failure. List only one cause on each line	he death. Do not ent	er the mode of dying	, such as cardiac	or respiratory arr	est,		Approximate Interval Between Onset and Death
-	Physician		resulting in death)	Myocardial	Infarcti	on				
ď	/Medical Examiner		Due to (or as a	consequence of):						
		Je.	Sequentially list conditions, if any, leading to immediate b. Due to (or as a	consequence of):						
	ecuted nd iransit	Examiner	Sequentially list conditions, if any, leading to immediate surse. Enter Underlying Cause (Disease or injury that initiated events							
8760,	icate be executed physician and the burial-transit	al Ex	resulting in death) Last Due to (or as a	consequence of):						
687		edical	d							
Box	eath certific attending p for use as	N/U	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth		☐ Ectopic pregnancy			23d. Date		
O. B	e deat the attri	Physician/Me	in the past 12 months? 1 □ Yes 2 □ No 4 □ Pregnant at		Other (specify)			Mont	h	Day Year
σ.	that the de ned by the a detached t		9 ☐ Unknown Part II. Other significant conditions contributing to death bu	t not resulting in the u	nderlying cause give	n in Part I.	23e. Did to	bacco use contrib	ute to th	e cause of death?
Division of Vital Records,	e ig	d by					1 □ Ye	es 2 No 3	☐ Prob	ably 4 Unknown
ဝွ	aw requir is been s 2 should	Completed					24a. Was a		ere auto	osy findings available inpletion of cause of
ď	The law ate has bage 2 s	lmo;					autops perfori 1 □Yes	ned? de	ath? ⊒Yes	
/ita	cian: ertifica ector, p	Be	25. Was case referred to medical examiner?		Law	26. Place of Deat	h (Check only or	e)		
€	Physician: The la r this certificate ha ral director, page 2		1 ☐ Yes 2€XNo Hospital: 1 ☐ Inpatier 27. Manner of Death 28a. Date of Injur	nt 2 ⊠ ER/Outpatier v 28b. Time o		4 Li Nursing no		ence 6 Other		y)
ono	ling J. After funer	tion	18⊠Natural 5 Pending (Month, Day, 2 Accident investigation		Work	? Yes 2 □ No	200. Describe III	w injury occurred	•	
Visi	Attending or death. ector: After by the fune	Certification: To	2 Could not be	ry - At home, farm, str (Specify)	reet, factory, office	£10	28f. Location (S City or Town	treet and Number	or Rura	l Route Number,
Ō	ital or irs afte ral Dir led in	Cert								
1	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	29a. Certifier (Check only one) 1 ★ Certifying Physician: To the best of any manner sta	examination and/or in	th occurred at the tin nvestigation, in my op	ne, date and place, pinion, death occur	and due to the ored at the time, or	cause(s) and mar late and place, ar	ner as s	tated. the cause(s)
1	To th within To th comp	Me	29b. Signature and title of pertitie		29c. License		2	29d. Date signed	(Month,	Day, Year)
) U \ M			645		()-1	10	
			30. Name and address of person who completed cause of de Scott A. Carter, MD, 7300			rel, MD 2	20707			
	Sta	ite	31. Date filed (Month, Day, Year) 32. Registra							
	Registi		JAN 1 4 2010 Censon &	· gares						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 23a, 25a per ME 8899 1/15/10 TT Amend 23a, State of Maryland Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 0150 Facility Name (If not institution, give street and number) anuary 112010 /Medical 4c. County of Death 4b. City, Town, or Location of Death **Examiner** The Johns Hopkins Hospital Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex . Age (In vrs. last birthday) **Funeral** Months 68 Director 217-36-3341 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits at 1 Yes 2 No Director iral", or items 23a or 28a-f s Examiner must be notified Maryland Harford Fallston with the 10f. Zip-Code 10g. Citizen of What Country? 10e, Street and Number 21047 USA Funeral 1503 Wildwood Drive death Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ₩ No ò Specify: Specify: 3 Widowed 4 Divorced 'natural" White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene. Real Estate Sales Realtor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Dorothy Helen Kress Henry (nmn) Williams မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1503 Wildwood Drive, Fallston, Maryland 21047 Frank Corso / Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or otl once. 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Bel Air Memorial Gdn : 1-16-10 Bel Air, Maryland 22. Name and Address of Facility
McComas Funeral Home, P.A. Funeral Service Licenses 21. Signature 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Effer the disease, or complications that caused the death. Do not enter the mode of dving, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Complications of brain cancer** Approximate Interval Between Immediate Cause (Final **Physician** disease or condition resulting in death) Arrway /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physician and as the burial-transit or Attending Physician; The law requires that the death certificate be executed CERTIFICATION APPROVED BY MEDICAL EXAMINER Due to (or as a consequence of): Box 68760. Physician/Medical as IF FEMALE: use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death Live birth 3 - Ectopic pregnancy in the past 12 months? Day Year Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9X Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records. 1 ☐ Yes No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 🗌 Yes 2 🗌 No 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Inpatient Other: 4 \sum Nursing Home 1 XYes 2 X No 2 ER/Outpatient 3 DOA ၉ 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending investigation Injury s after death. 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Cify or Town, State) filled in by 4 - Homicide determined Hospital 24 hours 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the To the To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier RE5-000 2010 M.D. SANUARY 11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St, Baltimore, MD, 21287 JASON LIAUW

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JAN 15 2010

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene = For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 14, 2010 Melchor Almendras Cabello January 0630 ΑМ /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** 4230 Hollins Ferry Road Apt. 219 Halethorpe Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 01/06/1935 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 XM 2 □ F 75 Philippines 566-58-5837 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it a Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2√No Directo Maryland | Baltimore Halethorpe 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4230 Hollins Ferry Road Apt. 219 21227 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Ayes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1963–69 1 □Yes 2 X No þ Specify: Asian 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) +2 Shipping/Receiving Pharmaceutical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Arcadio Cabello Marcaria Almendras ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Julia Cabello - Wife 4230 Hollins Ferry Road Apt. 219 Baltimore, MD 21227 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 NOther (Specify Finteriorent 01/18/2010 Baltimore, Maryland Parkwood Cemetery 21. Signature of Funeral Service Licenses 22. Name and Address of Facility David J. Weber Funeral Homes P.A. 401 S. Chester Street Baltimore, Maryland 21231 Approximate Interval Between Onset and Death 23a. Par 1. Enter the disease shock, or heart failure. List only incations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, the cause on each line. Immediate Cause (Final **Physician** METASTATIC YEARS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated events the burial-tran resulting in death) Last Due to (or as a consequence of): Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 5 Other (specify) 1 □Yes 2 □ No 9 Unknown rthis certificate has been signed by ral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1

Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 □ Yes 2 2 🗆 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \sum Nursing Home 5 \sum Residence 6 \subseteq Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 1 Inpatient 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) D16354 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 CATON AVE BALT. MD AGNES State

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Registrar

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** 2010 06 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Gardens
Social Security Number 6. 8 Buchmore Balto Cety Harborside Birthplace (State or Foreign Country) 6. Sex **Funeral** Year) 1 M 2 M 217-30-9023 Usual Residence of Decedent Director 11/19/1926 Baltimore, MA 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ns 23a or 28a-f show must be notified at 1 Nes 2 No Director timere 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4700 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No Race - American Indian, 11. Marital Status Black, White, etc. ☐Yes 2 Yes, Give Married 2 Married 1 ☐ Yes 2 ☑ NO Specify: Baltimore, Maryland 21215-0036 þ 3 ₩idowed 4 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) eal estate agent 18. Mother's Name (First, Middle, Maiden Surname, To Be BALTO, MP. Method of Disposition Burial 2 □Cremation 4 Donation 5 ☐ Other (Specify) 21. Signature of Faheral Service Licensee . Akarda In SKARDA Fill 2829 Hill ations that caused the death. To not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part1. Enter the disease, or cor o cations that cause shock, or heart failure. List only one cause on each Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as I consequence of): **Physician** /Medical Examiner allure to thru Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner with residual Right reded wakness with Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2₽No 3 Probably 4 Unknown recurrent dehydration Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1□ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: Certification: To 1 Inpatient 2 ER/Outpatient 3 ☐ DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year)

IAN 15 2010

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Baltimore, MD

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			For State Registrar	State of M	aryland		artmen <i>rtificat</i>				-	gien Reg. N	/ 11	0	00581
			Decedent's Name (First, Middle, La	st)							2. Date of De	ath			3. Time of Death
	Physici /Medi		David	Close							January	8	2010	e ar O	7:11 A ^M
0	Examir		4a. Facility Name (If not institution, given 5613 Gulf Stream Row	e street and number)			4b. City,		Location olumbi			40	County of		
	Funeral Director		294-44-0011	Sex 7. Ag	je (In yrs. la 63	ast birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da May 5,19	th i <i>y, Year</i> 46	9	. Birthpl Coun	lace (State or Foreign try) Ohio
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation							10	Od. Inside City Limits
	Maryl -f sho	to	Maryland Howa	ırd		C	Columbi	а							1 ☐ Yes 2 No
	n the	Director	10e. Street and Number				10f. Zip					10g. C	itizen of Wha	at Count	try?
	th wit		5613 Gulf Stream Ro	W				21044	ŀ			U.	S.A.		
	tems tems	Funeral	11. Marital Status	12. Was Decedent Armed Forces?		3. 13.	Was Deced	dent of Hi cify Cuba	ispanic Ori n, Mexicar	igin? (Sp n, Puerto	ecify Yes or No Rican, etc.)	-	14. Race - Black,	America White, e	
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland t Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Exemiter must be motified at	b	1 ☐ Never Married 2 ★ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☑ Yes 2 ☐ If Yes, Give Year or Dates:	Navy		1 □Yes	2 XX No	Specify:				Specify:	Wh	ite
5-	n 72 h	lete	15. Decedent's En (Specify only highest gra	ducation ade completed)		16a. Deced	dent's Usua kind of wor DO NOT us	al Occupa rk done d	ation <i>luring mos</i>	t of work	ing	16b. l	Kind of Busir	ess/Ind	ustry
12	withir lene. than	Completed	Elementary/Secondary (0-12)	College (1-4or 5	5+)	Softwa							Defen	se	
þ	il Hyg other	Be C	17. Father's Name (First, Middle, Last)				,		er's Name	e (First, Middle,	Maide			
<u>lar</u>	uld be Menta rked tic ev	To B	Blair Close						Phy	yllis	Balch				
Maryland	short land land lis ma		19a. Informant's Name/Relationship (Type. Print)		19b. Mailin	ng Address	(Street a	and Numb	er or Rur	al Route Numb	er, City	or Town, St	ate, Zip	Code)
	and and m 27		Pennie Close (Wif	ie)		5613 0					nbia, MD				
altimore,	ges 1 ar nt ot Hea If item or othe		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □	Removal from State	20b. Pl.	ace of Dispo emetery, cren	sition (Nan natory or o	ne of ther place	e) :		Date	20c. l	ocation - Cit	ty or To	wn, State
턡	it. Pa irtmer irtant: njury		4 ☐ Donation 5 ☐ Other (Special 21. Signature of Funeral Service Lice)		Fair	view Ce			j		-2010	Mad	ison, O	hio	
Ba	permit. Pages 1 Department of F Important: If ite any Injury or ot		21. Signature of Funeral Service Lice	isee		¶	hitzke 1555 Tw	Fûner vin Kn	al Hon olls I	iies, I Road	Inc. Columbia	, Ma	ryland	21045	5
þ	Physician /Medical Examiner	ler	23a. P. 11. Enter the decase, or composition in the composition of the	a. Cour Due to (or as	ne. Rary a constru WC	ence of):	nia	rese	arl			rrest,			Approximate Interval Between Onset and Death
68760,4	rtificate be executed ng physician and as the burial-transit	Aedical Examine	resulting in death) Last	c. Due to (or as	a consequ	ence of):	forti	~ O	Lneu	iry	Lm				
P.O. Box	Attending Physiclan: The law requires that the death certific refeath. octor: After this certificate has been signed by the attending p by the tuneral director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal	death 3	Ectopic p Other (sp		1				23d. Date of Month		ry Day Year
	w requires that the described signed by the should be detached	þ	Part II. Other significant conditions of	contributing to death b	ut not resul	Iting in the ur	nderlying ca	ause give	en in Part I			obacco Yes 2			e cause of death? ably 4 Unknown
Vital Records,	: The law re cate has bee page 2 sho	Completed	0		·						24a. Was autop perfo 1 □ Yes	an osy rmed? 2 2 N	prio dea	re autop or to con ith?]Yes	osy findings available inpletion of cause of
ita	iclan: The certificate rector, pag	Be C	25. Was case referred to medical examiner?							of Deat	h (Check only o				2 2 3 10
<u>5</u>	hysic this co		1 ☐ Yes 2 No	Hospital: 1 Inpatie		ER/Outpatien		Othe	er: 4□ Nu	rsing Ho	me 5 Resid	dence	6 ☐ Other	(Specify)
Division of	ending Physeath. or: After this he tuneral di	ation:	27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident investigation		iry y, Year)	28b. Time of Injury	M 2	8c. Injury Work 1 □ \	≀at ? ∕es 2□		28d. Describe I	now inju	iry occurred		
Divis	rs after du rs after do al Direct led in by t	Certification: To	3 Suicide 6 Could not be determined	28e. Place of Inj building, et	ury - At hor c. <i>(Specify,</i>	me, farm, stre	eet, factory	, office			28f. Location (8 City or Tov	Street a	nd Number e)	or Rural	l Route Number,
	To the Hospital or Attending Physician: To thin 24 hours after death To the Funeral Director. After this certific completely tilled in by the tuneral director.	Medical	29a. Certifier (Check only one) The Certifying Physics (Check only one) Medical Example (Check only one)	nysician: To the best niner: On the basis o and manner sta	f examinati	vledge, death ion and/or in	n occurred vestigation	at the tin	ne, date ar pinion, dea	nd place, ath occur	and due to the red at the time,	cause(date ar	s) and manr nd place, and	er as st	tated. the cause(s)
	To the vithing the confined the	Σ	29b. Signature and title of certifier	Brun	OW	10	290	License	number 952	2-6			ate signed ($108/2$		
	10		30. Name and address of person who FRANCIS BR	completed cause of d	leath (Item		Print)	116	ants	(olum	61	a, 1	nD	21044
	Sta	te	31. Date filed (Month, Day, Year)	5 2010 Registr	n's Signatu		1.)					

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AMEND ITEM#16a,b, perFH, G899, I/15/2010, WS

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ man January 112/3PM Medical 4a. Facility Name (if not institution, give street and number) Town, or Location of Death **Examiner** 4c. County of Death Baltimore Social Security Number If Under 1 Year I If Under 24 Hrs. 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) **Funeral** Months Days Min 1 XM 2 IF Director <u>214-50-3462</u> 61 01/12/1948 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director ¹X Yes 2 ☐ No BALTIMORE MD 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 708 DR. BENJAMIN QUARLES PL. 21201 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. ō Completed by 1 X Never Married 2 Married 1 Yes 2 XXVo Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: "natural", 3 Divorced Specify: Year or Dates BLACK injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha Disabled Disabled Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည ROBERT A. COLEMAN, SR. PRISCILLA WHITE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau ERICA COLEMAN/DAUGHTER 708 BENJAMIN QUARLES PL RALTIMORE. MD 21201 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place) BALTIMORE CREM.CTR. 1-14-2010 BALTIMORE, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee JAMES A. MORTON & SONS F.H., INC. BALTIMORE, MD 1701-31 LAURENS ST. 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician/ Keg PIRATOR disease or condition Medical resulting in death) Examiner CONE Secure fielly list on cliftons if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Be Completed by Physician/Medical Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Day Year signed by the a d be detached f 1 ☐ Yes 2 ☐ 9 ☐ Unknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy s certificate has b director, page 2 s perform Yes 2 No 2 🗌 No 1 🗌 Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 🗌 Yes Other: Certificate: To 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending 1 Yes 2 No Accident Suicide Investigation within 24 hours after death

To the Funeral Director: /
completed filled in by the f 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Praction@: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and 29d. Date signed (Month, Day, Year) OTL 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHRISTINE 32. Registrar State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** 13. 8:28 Shirley Ann Cantow January 2010 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Upper Chesapeake Medical Center Bel Air Harford 8. Date of Birth (Month, Day, Year)
NOV. 24, 1934 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Hours 1 □ M 2 🔀 F Maryland Director 214-30-6769 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, Its Medical Exercitival result by rediffied at 1 ☐ Yes 2X No Director Maryland Harford Forest Hill 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21050 1610 Honeysuckle Drive USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status is 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene.
Item 27 Is marked other than "natural", or ite 1 ∐Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Cecelia (unk) Friedel ပ Jessie (nmn) Jurnigan Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) E. Carol Kerr / Daughter 1436 Hallowell Lane, New Windsor, Maryland, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition of i permit. Pages Department of Important: If it any injury or c 1 🔀 Burial 2 □ Cremation 3 🗀 Removal from State 1/16/2010 4 Donation 5 Other (Specify) Parkwood Cemetery Baltimore, Maryland 21. Signal of Fundral Service 22. Name and Address of Facility McComas Funeral Home, P.A. 50 W. Broadway, Bel Air, Maryland 21014 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final # 5 **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Acite Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Examiner attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 Other (specify) signed by the a 1 ☐ Yes 2 ☑ No 9 T Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown AUTO, MANAS Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed certificate 1 ☐ Yes → ⊟No 1 □Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To this 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? After 1 Natural 5 Pending investigation 1 ☐Yes 2 ☐ No death. Director: d in by the 2 ☐ Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide within 24 hours a To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 1/13/10 166342 KapilKumar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) UPPER CHESAPEAKE 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 1-2010 6:30 PM ameror Medical 4a. Facility Name (if not institution, give street and number) 4b City, Town, or Location of Death Examiner 4c. County of Death aguna Lour 8. Date of Birth (Month, Day 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 1 №M 2 🗆 F Months Country) Director Usual Residence of Decedent ıral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County 10e. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No tou 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces? Black, White, etc. þ 1 Never Married 2 Married 2 No 1 ☐ Yes If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: Black "natural" Completed 3 Divorced Year or Dates Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) , Mother's Name (First, Middle, Maiden Surname) should be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2: Department of Health MD 2/133 Baltimore, 20b. Place of Disposition (Name of centery, crematory or other **S**ate 20a. Method of Disposition 20c. Location -City or Town, State Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 28 MD21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Due to r as a consequence of): Pnysician/ disease or condition resulting in death) 1.5413 a Medical Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) ig physician and as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical been signed by the attending should be detached for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Day Other (specify) Year Pregnant at time of death 1 ☐ Yes 2 ☐ Unknown Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has I page 2 s performe certificate 2 No Yes 2 1 Yes 25. Was case referred to medical examiner?

1 Yes 2 No **Division of Vital** funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 Inpatient 2 I ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred After 1 Natural 5 Pending injury 1 Yes 2 🗌 No ☐ Accident Investigation within 24 hours after death

To the Funeral Director: A 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \square Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check the only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year, 62370 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michelle Sacre Baltimore, MD. 2120 32. Regis State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death catus Day **Physician** DONOTHY 6:00AM 2-2010 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Enfield Howard Stock Wood apt. 320 10801 B. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 220-38-75F6 Usual Residence of Decedent 1 □ M 2 💢 F **Director** filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State s 23a or 28a-f show 1 ☐ Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 2116 . Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No IfYes, Give Year or Dates: Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after de: Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, Inc. Publical Exp. it in L. it. Once. 11. Marital Status 1 Never Married 2 Married 1 □Yes 2 ☑No Baltimore, Maryland 21215-0036 Specify. ģ Blac 3 ☐ Widowed 4 ☑ Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) ve Gwynn Oak mu 31207
Date 20c. Location - City or Town, State atonyamcalain 20b. Place of Disposition (Name of cemptery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 Removal from State Balto. mo 6-2010 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility auch · Greene Funeral Service 21. Signature of Funeral Service Lice 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner be executed and s a consequence of): burialattending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 □ Yes 2 No
9 □ Unknown Pregnant at time of death 5 Other (specify) P.0. the 9 Unknown signed by t I be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Records, ģ 3 Probably 4 Unknown 2**1** No 1 🗌 Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an icate has t page 2 s autopsy certificate 1 ☐ Yes 2 ☐ No 2 No 1 ☐ Yes Division of Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 1 5 ☐ Pending investigation 1 Natural 2 ☐ Accident 1 ☐Yes 2 ☐ No within 24 hours after death.

To the Funeral Director; A completely filled in by the fu 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. To the h 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie

State Registrar 31. Date filed (Month, Day, Year)

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32. Regi grar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

gnal Bell lane Clarksulle MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 4 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2010 JANUARY 9:06 A M Physician/ DORIS LORRAINE CHASE Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner MONTGOMERY NATIONAL INSTITUTES OF HEALTH BETHESDA 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Country) Funeral Days Hours Min 08/06/1959 1 □ M 2 🖺 F MD 50 Director 578-78-9184 Usual Residence of Decedent 10d. Inside City Limits and 2 should be filed within 72 hours after death with the Maryland Heath and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County Director 1 K Yes 2 No Washington NONE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral USA SE #403 20020 3103 Pennsylvania Ave. 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 X Never Married 2 Married þ 1 Yes 2 No Specify: Maryland 21215-0036 Specify: Black 3 Widowed 4 Divorced Completed Year or Dates 16b. Kind of Business Industry 16a. Decedent's Usual Occupation 15. Decedent's Education Give kind of work done during most of working (Specify only highest grade completed) life DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Reagan Nat. Airport Security Officer llth grade Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Dorothy Harris Charles Chase 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 10648 Montrose Ave. #104 Bethesda, MD 20814 Myron Weaver/Son 20c, Location - City or Town, State Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State 0 Harmony Mem. Park 01/15/2010 Landover, MD injury 4 Donation 5 Other (Specify) 22. Name and Address of Facility Marshall's Funeral Home . Signature of Funeral Service Licensee once. any 4217 9th St NW Washington DC 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Influenza Medical resulting in death) Due to (or as a consequence of) eeirs Examiner Sendo Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last attending physician a Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Month Day Year in the past 12 months?
1 Yes 2 No Pregnant at time of death 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 \(\sigma\) No 1 Yes 26. Place of Death (Check only one) 25. Was case referred to medical within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, I Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No Inpatient 2 ER/Outpatient 3 DOA 1 Yes ၀ 28c. Injury at work? 28d. Describe how injury occurred 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death Certificate: 1 X Natural 5 Pending 1 Yes 2 No Investigation Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 🗆 Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Cartifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and the of certifie 29c. License number 2010 281 of person who comp eted cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 7/2009

State

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31. Date filed (Month, Day, Year)

10 CENTER DRIVE, BETHESDA, MARYLAND 20892

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Ja^{Month} Day 201 dear Micheal S. Cleveland 12 4: 58pm Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 305 E. Joppa Road Eudowood Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Months Days Min. Oct. 3, 1952 219-58-1395 57 **Director** MD Usual Residence of Decedent or 28a-f shov 10a. State the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director Baltimore MD Eudowood 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 305 E. Joppa Road 21286 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ★ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. à 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 21 No Specify. "natural", Specify:White 3 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nould be filed within 72 and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Disabled Disabled Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be filed and Mental H is marked of 2 Harry Cleveland Carol Sadowski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 s Health tem 27 Janice MArshall 828 Dorsey Avenue Baltimore MD 21221 item 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date ģ 1 🛣 Buriel / 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) ō Owings Mills MD Garrison Forest 1/21/10 Important injury (21. Signature of Funeral Service Licens ^{22. Name and Address of Facility} 300 Mace Ave. Balto. Connelly Funeral Home of Essex MD 21221 23a. Part 1. Enter the disease, or complications, at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Onset and Death acuto Physician/ 125/40 Medical Examiner Due to (or as a consequence of): 12/12 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine burial-transit attending physician for use as the buria Physician/Medical 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery Box 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month signed by the a d be detached f 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 05 fearifelens Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy Director: After this certificate I in by the funeral director, pag 1 ☐ Yes 2 ☐ No 1 🗌 Yes 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 Natural injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, determined 124 hours a Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) anes

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day,

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death Physician/ January 201Ŏ^{ear} Nicolas Rodrigo Chaparro 10:30 РΜ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Montgomery Potomac 11611 Milbern Drive 6. Sex 1 🛣 M 2 🗆 F If Under 1 Year If Under 24 Hrs. 5. Social Security Numbe 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min. April 14, ^{3ar)} 1997 Months Days Hours 770-01-0327 12 Colombia **Director** Usual Residence of Decedent shov 10a. State 10b. County 10c. City, Town or Location with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at 10d. Inside City Limits Director Potomac 1 ☐ Yes 2 🕅 No Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States/ Funeral 20854 11611 Milbern Drive Colombia permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S 14. Race - American Indian. Armed Force Black, White, etc. 1 X Never Married 2 Married 2 Yes 2 No Baltimore, Maryland 21215-0036 1 X Yes 2 □ No Specify: Colombian If Yes, Give Specify: White 3 Widowed 4 Divorced Completed Year or Dates I and Mental Hygiene.

7 is marked other than "natur 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Student Education other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Sonia Vasquez Luis Rodrigo Chaparro 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11611 Milbern Drive, Potomac, Maryland 20854 Luis Rodrigo Chaparro/Father 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date January þ 1 Burial 2 X Cremation 3 Removal from State Department of Important: If any injury or once. Bethesda, Maryland Montgomery Crematorium, Inc 4 ☐ Donation 5 ☐ Other (Specify) 2010 Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Rockville, Inc Madelette M01305 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 23a. Part 1. After the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final 2 Mon ths Progressive Brain Tumor Pnysician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner 10 Months Anaplastic Astrocytoma Sequentially list conditions, Street of for as a nonsequence of cause. Enter Underlying Cause (Disease or linjury attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical certificate be Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy or Attending Physician: The law requires that the death in the past 12 months? 5 Other (specify) Month Yes 2 No signed by the a 1 ☐ Yes 2 ☐ 9 ☐ Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ Division of Vital Records, cate has been sig 2 X No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 N certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 2 🛚 No ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this nours after death.

neral Director: After the filled in by the funeral 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) X Natural 5 Pending 1 Yes 2 No Investigation Accident 6 Could not be Suicide 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral D Hospital Medical 🖄 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. UNIVERSE 33 Gertifying Nurse Fractioner: T. the best of my knowledge, best permed at the time date and place, and are to the cause(s) and manner as stated 29b, Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 2. Reg strar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Brian R. Rood, MD

31. Date filed (Wanth, Day, Year) JAN 1 4 2010

D0055584

111 Michigan Avenue, NW, Washington, D.C. 20010

January 11, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Randallstown
If Under 1 Year | If Under 24 Hrs. Seasons Hospice 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 🙀 F Yrs. 78 28, 1931 Director Nov. Maryland 215-28-0107 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d, Inside City Limits 10a. State items 23a or 28a-f show Department of Heatth and Mental Hygiene. Important: 'or items 23a or 28a-f show any injury or other traumatic event, the Wedical Examinations to the traumatic event, the Wedical Examinations that he notified at 1 ☐ Yes 21 No Directo Baltimore Randallstown 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 8616 Allenswood Road 21133 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ∐Yes 2 ⊠No 2 Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Leyton S. Edna Knapp Appler, Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald G. Childs Husband 8616 Allenswood Road Randallstown, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Jan 16, 2010 Pikesville, MD Druid Ridge Cem. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 11824 Reisterstown Road J. Wayne Osterling Reisterstown, MD 21136 Eline Funeral Home Approximate Interval Between Onset and Death 23a. Par 1. Enthathe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consiquence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): the Hospital or Attending Physician; The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Dav 5 ☐ Other (specify) 1 □Yes 2 No P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 NO 1 ☐ Yes 1 □Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 \sum Nursing Home 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral D 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated.

DHMH 17 Rev 1/2001

State Registrar

29b. Signature and title of certifier

283 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2010 January 10:35A M ${\tt Crowlev}$ <u>Georgia</u> <u>Marie</u> Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel 1067 Omar Drive Crownsville If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, 1 □ M 2 🗓 F 19<u>44</u> Months Days Hours Min. Maryland Director 217-40-6051 65 Aug. Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a. State 10d. Inside City Limits 10c. City. Town or Location Director 1 Yes 2 No Maryland | Crownsville <u> Anne Arundel</u> 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a Funeral 1067 Omar Drive 21032 U.S.A. within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 ☐ Widowed 4 ☐ Divorced Specify: Completed White Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Homemaker Housewife & Mother Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည George Walters Mary Agnes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Husband) Melvin Crowley, 1067 Omar Drive Crownsville Maryland 21032 Charles Sr. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 A Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Cremation 01/11/10 Glen Burnie, Maryland 21. Signature of Fineral Service Licensee 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland 21122 Kevin E Ecker 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death ARC 1 Physician disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Examine cause. Enter Underlying or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events burial-tran Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Box 68760 the attending pl IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death s been signed by the s Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ Mo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available 24a. Was an has page 2 autopsy prior to completion of cause of performed Yes 2 this certificate 1 ☐ Yes 2 ☐ XNo Division of Vital 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 **X**No 1 🗌 Yes 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27, Manner of Death 28a. Date of injury 28b. Time of nours after death. neral Director: After the filled in by the funeral 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) 1 Natural injury 5 Pending 1 🗌 Yes 2 🗌 No М ☐ Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours after of Funeral Direct 4 Homicide determined building, etc. (Specify) To the Hospital Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner, On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

Registrar
DHMH 17 Rev 7/2009

State

110

completed cause of death (Item 23a) (Type, Print)

De

31. Date filed (Month, Day, Year)

And the property of the proper				Please Type or P State of State Registrar			of Health and	Mental Hyg	_	0 00591
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The companies of the content of th				5. Social Security Number 6. Sex 7	. Age (In yrs. last bir	thday) If Under 1	Year If Under 24 Hrs	8. Date of Birth Month, Day,		irthplace (State or Foreign Country)
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Eleveratery/Secondary/Se		r death	nera	11 Marital Status 12. Was Deced	ent Ever in U.S.			Specify Yes or No-	14. Race - An	
Eleveratery/Secondary/Se		urs after al"; or it	by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ If Yes, Give	No No	1 _	_	to mount, etc.)		_
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Approximation Security Displaying Committee Security Displaying	5 5	d withi	Comp						Food Serv	vice
Approximation Security Displaying Committee Security Displaying	- "	d be file ental Hy ked oth	Be	, , ,					,	
Approximation Security Displaying Committee Security Displaying	8 2	2 shoul and M is mar aumati	Ě	19a. Informant's Name/Relationship (Type. Print)	19b	. Mailing Address (S				, Zip Code)
Approximation Security Displaying Committee Security Displaying	(A)	1 and Health em 27 other tr		, ,						
22. Same and Address of Facility Schimunek Funeral Home of Br. Inc 610 W. MacPha11 Rd Bel Air, MD 21014 Approximate shock or heart failure. List cety one cause on each fine. Physician Medical Example (Fine Br. List cety one cause on each fine. Physician Medical Example (Fine Br. List cety one cause on each fine. Inc 610 W. MacPha11 Rd Bel Air, MD 21014 Approximate shock or heart failure. List cety one cause on each fine. Inc 610 W. MacPha11 Rd Bel Air, MD 21014 Approximate shock or heart failure. List cety one cause on each fine. Inc 610 W. MacPha11 Rd Bel Air, MD 21014 Approximate shock or heart failure. List cety one cause on each fine. Inc 610 W. MacPha11 Rd Bel Air, MD 21014 Approximate shock or heart failure. List cety one cause on each fine. Inc 610 W. MacPha11 Rd Bel Air, MD 21014 Approximate shock or heart failure. List cety one cause on each fine. Inc 610 W. MacPha11 Rd Bel Air, MD 21014 Approximate shock or heart failure. List cety one cause on each fine. Inc 610 W. MacPha11 Rd Bel Air, MD 21014	2012			1 XBurial 2 ☐ Cremation 3 ☐ Removal from St	ate cemeter	ry, crematory`or othe	er place)		ŕ	
23a. Part I. Einter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Interval Electronic Constructions and control of the cont	→ =	permit. Departn Importa any inju		21. Signature of Fundal Service Licenson		22. Name and	Address of Facility So	himunek l	Funeral Ho	ome of BelAir
Due to (or as a consequence of): Ather A A Based Ba	- 4			Immediate Cause (Final disease or condition resulting in death)	Cardial	not enter the mode of	of dying, such as cardia			Approximate Interval Between Conset and Death
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The state of the s	72.5 Box	the death certific by the attending p iched for use as	ysician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 23c. If yes, outco	th 2 Fetal death nt at time of death				1	,
The state of the s	s.	quires that in signed to	ò	Part II. Other significant conditions contributing to deal	h but not resulting in	the underlying caus	se given in Part I.		_	to the cause of death? Probably 4 □ Unknown
25. Was case referred to medical examiner? State)483 I Reco	The law re ate has bee	complete	Ocute Renal Carlaire				autopsy perform	prior to led? death?	completion of cause of
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Angela Pope Ries 500 upper Chesapacke Dr. Bel Air, MD 21014 State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	SOC Vita	ician: certific ector,	Be	examiner?			T			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Angela Pope Ries 500 upper Chesapacke Dr. Bel Air, MD 21014 State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	N P	ig Phys ter this neral dii	<u>ان</u>	27. Manner of Death 28a. Date of	Injury 28b. 1		4 LI Nursing I			ecify)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Angela Pope Ries 500 upper Chesapacke Dr. Bel Air, MD 21014 State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	isior	ttendir death. ctor; Af y the fun	catic	2 Accident investigation		M	1 ☐ Yes 2 ☐ No	20f Logation (Ctr	and and Alizabay and	2. and 10 and Alexandra
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Angela Pope Ries 500 upper Chesapacke Dr. Bel Air, MD 21014 State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	Div	ital or A rs after al Direction by	Certi					City or Town,	State)	
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Angela Pope Ries 500 upper Chesapacke Dr. Bel Air, MD 21014 State 31. Date filed (Month, Day, Year) 32. Registrar's Signature	15	the Hospi nin 24 hou the Funer npletely fil	edical	(Check only 2 Medical Examiner: On the bas one) and manne	is of examination an	d/or investigation, in	my opinion, death occ	e, and due to the ca urred at the time, da	luse(s) and manner ite and place, and di	as stated. ue to the cause(s)
Angela Poppe Ries 500 Upper Chesapeake Dr. Bel Air, MD 21014 State 31. Date filed (Month, Dayl Year) 32. Registrar's Signature		vitt Ton	2	29b. Signature and title of certifier	MD	29c. L	icense number	827 29	d. Date signed (Mor	oth, Day, Year)
				Angela, Prope Ries 500	of death (Item 23a) (Type, Print)	Ke Or T	Bel Air	mo	21014
register GANT 7 ZUTU Charles . M. As all I		Stat Registra		31. Date filed (Month, Day, Year) JAN 1 4 2010	istrar's Signature	a de d	7 0 101	-4-111	1113.0	

	Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND, TTEM#10e, 19a, 20b, perFH, g900, 2/16/2010, WS State of Maryland 7 Department of Health and Mental Hygiene													
1 - State Registrar Certificate of Death Reg. No 2010 0059											00592			
	1. Decedent's Name (First, Middle, Last) Physician/ Nellie Catherine DeFrancesco Month Day Year 1/9/2010									Year	3. Time of Death 6:20pm M			
)		Medical Examiner 4a. Facility Name (if not institution, give street and number) Collingswood Nursing & Rehab Center 4b. City, Town, or Location of Death Rockville, MD 4c. County of Death Rockville, MD									h			
	Funeral		5. Social Security Number 048-05-1886	6. Sex	7. Age	e (In yrs. las	st birthday)	If Under Months	1 Year Days	If Under 24 Hrs Hours Min.	(Month, D	ay, Year)		thplace (State or Foreign untry)
	Usual Residence of Decedent									CF				
	Maryland 28a-f sho atified at	rector	10a. State 10b. Co		tgomery	10c. City,	, Town or Lo	cation	Ro	ckville				10d, Inside City Limits 1 ☐ Yes 2 ☑ No
	with the I s 23a or 2 ust be no	Funeral Director	10e. Street and Number 299 Hurley	Aven Road	ue			10f. Zip	Code	20850		10g. Citizen		ountry? SA
980	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Department of Health and Mertal Hygiene. Inproprant; If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 ☐ Never Married 2 ☐ 3 ፟፟፟ Widowed 4 ☐ Divo	Married	2. Was Decedent E Armed Forces? 1 ☐ Yes 2 X If Yes, Give Year or Dates.		'	Was Deced f Yes, spec 1 Yes	ify Cuba	spanic Origin? (Sp n, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)		Race - Ame Black, White cify:	rican Indian, e, etc. white
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Maryland 21215-0036	ld be filed Mental Hy arked oth atic event	To Be	17. Father's Name (First, Mid Peter No	ile, Last) vak					:	18. Mother's Nai	ne (First, Middle Le Koloc		ame)	
, Mar	nd 2 should be ealth and Ment m 27 is marked ler traumatic e		19a. Informant's Name/Rela		, Print) ·/ Daught	er				on Dr.,				
Baltimore,	permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Crema 4 ☐ Donation 5 ☐ Ot		temoval from State		ace of Dispo metery, cren Cash	osition (Nan natory or o	ther place	e) 1/1	Date 6/10	20c. Locati	•	Town, State d, CT
Balt	permit. Departi Import any inj		21. Signature of Funeral Sen	ice Licensee	Victor P	Doc	3a Th-22	. Name an	d Addres	s of Facility Stever Ort Ave	ns_Funei	al Hom	e, In	ç.
			23a. Part 1. Enter the disease shock, or heart failure.	e, or complication	cations that caused	the death							2123	Approximate Interval Between
	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	a		e conseque	on 1°	۹.						Onset and Death
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		ical E	resulting in death) Last		Due to (or as a	a conseque	ence of):						.\\	
Box 68760	the Hospital or Attending Physician. The law requires that the death certificate be exching 4 thin 24 hours after death. Inin 24 hours after death. Ithe Funeral Director. After this certificate has been signed by the attending physician the Funeral Director. After this certificate has been signed by the attending physician mpleted filled in by the funeral director, page 2 should be detached for use as the burial	Physician/Medica	IF FEMALE: 23b. Was decedent pregnand in the past 12 months? 1 — Yes 2 🖪 No 9 — Unknown	23	3c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 Fetal	death 3	Ectopic p		у		23d	Date of de Month	livery Day Year
, P.O.	es that th signed by I be detad	by	Part II. Other significant co	editions con		ut not resu	Ilting in the u	underlying o	cause giv	en in Part I.				the cause of death?
ords	w requir	Completed		0,000							24a. Wa		1b. Were au	topsy findings available completion of cause of
Rec	: The la cate ha ; page?										per 1 🗌 Yes	formed?	death?	s 2 💢 No
/ital	/sician s certifi director	To Be	25. Was case referred to med examiner? 1 Yes 2 No	- 12	ospital:	ent 2 🗆 F	ER/Outpatier	nt 3 🗆 DO	Othe	ace of Death (Che	ck only one) Home $5 \square$ Res	idence 6 🗆	Other (Spec	(fv)
n of \	nding Phy th. : After this s funeral o	cate: 1	27. Manner of Death 1 Natural 5 P 2 Accident In	ending /estigation	28a. Date of inju (Month, Day	ry :	28b. Time of injury		8c. Injury work	at	28d. Describe		_	,,
Division of Vital Records,	I or Atter after dea Director I in by the	Certificate:	3 □ Suicide 6 □ C	ould not be termined	28e. Place of Injubulding, etc			eet, factory	, office			(Street and Nu wn, State)	mber or Ru	ral Route Number,
	To the Hospital or Attending Physician: The law require within 24 hours after death. Ot the Funeral Director: After this certificate has been si completed filled in by the funeral director, page 2 should I	Medical	(Check 2 Med	cal Examine	cian: To the best of er: On the basis of e Practioner: To the	xamination	and/or invest	tigation, in	my opinio	n, death occurred	at the time, date	and place, and	due to the	cause(s) and manner stated.
7	To the within To the comp	2	29b. Signature and title of ce		Ilm	0		290	. License	6243	5	29d. Date si	gned (Monti	h, Day, Year)
			30. Name and address of pe	son who con	mpleted cause of d	eath (Item	23a) (Type, F			ar Dr.	Rod	Cville	, ME	20850
	Sta Registra		31. Date filed (Month, Day, You JAN 1 4	,	22. Registra	ar's Signatu	ure	الما						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 00593 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ Month 10:30 p м 2010 Dietz J<u>anuary</u> Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Havre de Grace Citizens Care and Rehabilitation Harford If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthdav) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) Iowa Days Hours Jan 26 Day, Y 213-20-0808 86 1923 Director Usual Residence of Decedent or 28a-f show notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2**X** No Harford Havre de Grace Maryland 5 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a o Examiner must be Funeral 21078 United States 20 Pine Street 40 Robinhood Road within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify "natural", 3 ☐ Widowed 4 ☐ Divorced Specify: Completed White Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working should be filed within 72 In and Mental Hygiene.

7 is marked other than "r life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ William Waddell Rose Kalloway 1 and 2 should to the stand the stan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathleen Lord/ Granddaughter 1303 Bartley Place, Belcamp, Maryland 21017 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1. Department of Important: If it Januar 1 Burial 2 🔀 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Metro Crematory, Inc. 2010 Baltimore, Maryland 22. Name and Address of Facility Cremation Society of Maryland, Inc of Funeral Service Licensee Amanda Heaston 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death shock, or heart failure. List only one cause Immediate Cause (Final Physician/ 2M onta Medical resulting in death) to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to for as a consequence on: physician and the burial-transit that initiated events resulting in death) Last Physician/Medical The law requires that the death certificate be Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 - Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) Day Pregnant at time of death ed by the detached 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has I death? performed certificate 2 🗀 No Yes 2 1 🗌 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Division of Vital Hospital or Attending Physician: 25. Was case referred to medica 26. Place of Death (Check only one) Be 1 Tyes 2 No Other မ 1 Inpatient 2 I ER/Outpatient 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending Accident 1 🗌 Yes Investigation Suicide 6 Could not be ☐ Suiciue ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a, Certifier 🕊 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29d. Date signed (Month, Day, Year) ρ 12 10 Mame and address of per se of death (Iten 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar n, Day, Year,

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene
Amend Items 2,3 per np 8899,01/15/2010dhb,29a per dvr
Certificate of Death
Reg. No. 1 - For State Registrar 2. Date of Death 01/10/2010 Nonth Day 10/2010 13 Time of Death Nonth 1. Decedent's Name (First, Middle, Last) 61/15 FRANKlin 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death

Physician

/Medical

Examiner

1			101 OISBUIN DIIVE. Joppa		LATIOI	. a
	Funeral Director			8. Date of Birth (Month, Day, X Sept. 12	9. Birth Cou	place (State or Foreign ntry) VA
	p ,		Usual Residence of Decedent			
	Marylar a-f shov	tor	10a. State			10d. Inside City Limits 1 ☐ Yes 2X No
	vith the	Director	10e. Street and Number 101 Orsburn Drive 101. Zip Code 21085	10g	. Citizen of What Cou USA	ntry?
	ns 23a	Funeral		cify Yes or No-	14. Race - Ameri	can Indian
136	I be filed within 72 hours after death with the Maryland ntal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be recitive at	by Fur	11. Marital Status 1 □ Never Married 1 □ Never Married 3 □ Widowed 4 □ Divorced 1 □ Never Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No If Yes, specify Cuban, Mexican, Puerto R 1 □ Yes 2 □ No Specify: 1 □ Yes 2 □ No Specify:	lican, etc.)	Black, White, SpecifyWhi	etc.
2-Ç	72 hou natura iical E	eted	15. Decedent's Education 16a. Decedent's Usual Occupation	16	b. Kind of Business/Ir	ndustry
21215-0036	within ene. than "	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	9	Ellis T	Ruckin
N	Hygi Hygi Ither Int, II	S	17. Father's Name (First, Middle, Last) 18. Mother's Name (18. Mother	(First Middle Ma		
Maryland	should be 1 nd Mental marked o imatic eve	To Be	John C. Ellis Julia S		iden Surname)	
, Mar)	ind 2 shoralth and I		19a. Informant's Name/Relationship (Type. Print) Anna Mae Ellis /wife 19b. Mailing Address (Street and Number or Rural 101 Orsburn Drive J	Route Number, C Joppa M	City or Town State, Zi d 21085	o Code)
saltimore,	Pages 1 a ent of He nt: If item ry or othe		20a. Method of Disposition 1		c. Location - City or To Rossvill	
Balti	permit. Pages 1 and 2 should be Department of Health and Ments Important: If item 27 is marked any injury or other traumatic es				Ave. Bal	
			23a. Part 1. Enter the disease, or complications that caused the leath. Do not enter the mode of dying, such as cardiac or			Approximate
	Physician	l n	shock, or heart failure. List only one cause on each line	, ,		Interval Between Onset and Death
	/Medical		disease or condition resulting in death) Due to (or as a consequence of):		1	
	Examiner					
-	po tis	iner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated areas.) Due to (or as a consequence of):			
	execute and al-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
08/00,	te be e	calE	d			
8	rtifica ng ph as th	Ved	IF FFMALE.			
C. BOX	equires that the death certificate be executed en signed by the attending physician and uid be detached for use as the burial-transit	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 1 □ Live birth 2 □ Fetal death 5 □ Other (specify)		23d. Date of deliv Month	ery Day Year
ŗ	that the ed by detac	Ph		23e. Did tobac	co use contribute to t	he cause of death?
Jrds,	equires een sign ould be	e G	Coner May Anthrop District District Coner May Anthrop District			bably 4 Unknown
incon.	has be	Complet	,	24a. Was an autopsy	prior to co	opsy findings available ompletion of cause of
<u> </u>	icate ; pag	ខ្ល		performed 1 □ Yes 24	death? No 1 ☐ Yes	2 No
2	certif ector	Be	25. Was case referred to medical examiner? Hospital: Other: Other:	(Check only one)		
5	Phys this al dir	P	1 Inpatient 2 EH/Outpatient 3 DOA 4 Nursing Home		e 6 Other (Speci	fy)
1121011	ending sath. or: After he funer	ertification: T	1 Natural 5 Pending (Month, Day, Year) Injury Work? 2 Accident investigation M 1 Yes 2 No	3d. Describe how i	injury occurred	
	al or Att s after de il Directe ed in by t	Certific	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28	Bf. Location (Stree City or Town, S	et and Number or Rur. State)	al Route Number,
	To the Hospital or Attending Phystolan: The law re within 24 hours after death. To the Funeral Director: After this certificate has bee completely filled in by the funeral director, page 2 sho	Medical (29a. Certifler (Check only problem in the basis of examination and/or investigation, in my opinion, death occurred one) Nurse Practioner.	nd due to the caus d at the time, date	se(s) and manner as and place, and due t	stated. o the cause(s)
	To th withir To th comp	Me	29b. Signature and title of certifier 29c. License number	29d.	. Date signed (Month,	Day, Year)
			Newtand & I may cant RO462	20	01-11-	2010
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rechard C. TROY CRAP 3500 LOCA RAVER Blvs	BALTIN	ore Mp 2	1218
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature	/	-/	
	Registra	ar	JAN 1 4 2010 Remet S. Janes			
21.12	4H 47 D 4 (00	0.4	· · · · · · · · · · · · · · · · · · ·			

State Registrar

1500 Forest Glen Rd., Silver Spring, MD 20910 M.D. Kanwaljit Nagi, 31. Date filed (Month, Days) 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year 9:30 AM Physician 2010 Januaru /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. Social Security Number 6 Sex 7. Age (In vrs. last birthday) Year **Funeral** Min. Months Days Hours 1 M 2 F Yrs. Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinar must be rediffed at 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 ☐ Yes 2 ☑ No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐Yes 2 ☐No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2 ☑ No Baltimore, Maryland 21215-0036 Specify. 2 3 ☐ Widowed 4 ☑ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) ASIOR 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 93 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, cramatory or other) 20a. Method of Disposition matory or other place) 1 ■ Burial 2 □ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facil 21. Signatur Funeral Service 23a. Part Epterune disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immedia Cause (Final disease or condition) Approximate Interval Between Onset and Death Atherosc lears Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner requires that the death certificate be executed ng physician and as the burial-tran and Due to (or as a consequence of) Box 68760, Physician/Medical attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 5 Other (specify) P.0. 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? s been signed to should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 4 Unknown 2 ☐ No 3 ☐ Probably 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an nis certificate has I director, page 2 s autopsy 2 No 2. No 1 ☐ Yes 1 ☐ Yes or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 ER/Outpatient 3 DOA 1 Yes 2 🗆 No 1 🔲 Inpatient within 24 hours after death.

To the Funeral Director: After this of completely filled in by the funeral director. Certification: To 28d. Describe how injury occurred . Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated.

State Registrar

31. Date filed (Month

OLA

29b. Signature and title of certifier

MANISH

00 (4 32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

and

	Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #2 per MD 9901 3/10/10 TT State of Maryland / Department of Health and Mental Hygiene									
Terrificate of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg, No. 2010 0051									00597	
	Physicia	ın/	1. Decedent's Name (First, Middle, Last)	51/1001			2. Date of Death J		3. Time of Death	
	Medic Examin	cal	4a. Facility Name (if not institution, give stree	ELLISON et and number)	4b. City, Town, or	Location of Death	1-8-	c. County of Dear	- UN KNOWN	
	<i></i> —_———		3707 Marrid 5. Social Security Number 6. Sex	tsville, Ro	Rano hday) If Under 1 Year	la 15to	-	Balt	imore	
	Funeral Director		214-56-4658 1.8M	7. Age (In yrs. last birt	Yrs. Months Days	Hours Min.	8. Date of Birth Month, Day, Year	9. Bir	thplace (State or Foreign untry)	
	and show at	้อ	Usual Residence of Decedent 10a. State 10b. County	10c City, Town	n or Location				10d. Inside City Limits	
	Maryla 28a-f	Director	MD	'Ka	ndalist	ω_{Ω}			1 🗆 Yes 2 🗖 No	
	with the	Funeral C	10e. Street and Number	ottsville R	10f. Zip Code	33	10g. 0	Citizen of What Co	ountry?	
	r death	/ Fun	11. Marital Status 12.	Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No	13. Was Decedent of His If Yes, specify Cubar	spanic Origin? (Spec n, Mexican, Puerto R	ify Yes or No- ican, etc.)	14. Race - Ame Black, White		
21215-0036	72 hours after death with the Maryland n "natural", or items 23a or 28a-f sho ledical Examiner must be notified at	ted by		1(□ res 2 □ No If res, Give Year or Dates.	1 🗆 Yes 2 📉 No	Specify:		Specify:	lack	
15-(72 hou	Completed	15. Decedent's Educat (Specify only highest grade co	ompleted)	Decedent's Usual Occupa (Give kind of work done do life, DO NOT use retired)		g 16b.	Kind of Business	Industry	
	d within lygiene. her thar nt, the M	Be Col	1200	Cellege (1-4 or 5+)	Formation	Tech		xial.Se	curity Adminis	
Maryland	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	일 일	17. Father's Name (First, Middle, Last)	llison Se	:	18. Mother's Name	(First, Middle, Maidel	n Surname) Rro	in tow	
Aary	should be file n and Mental h 7 is marked o raumatic eve		19a. Informant's Name/Relationship (Type, F	Prin(Sister) 196	. Mailing Address (Street a			or Town, State, Zij	(CO)	
	permit. Page 1 and 2 s Department of Health Important: If item 27 any injury or other tr once,	,	20a. Method of Disposition	20b. Place o	140 Walt f Disposition (Name of	hers A		Location - City or	21239 Town, State	
Baltimore	Page 1 ment of tant: If it jury or o		Burial 2 Cremation 3 Rem	noval from State	ry, crematory or other place	meloy 1/1	9/20100	Oinas M	ills MD	
Bai	permit. Page Department Important: any injury o		21. Signature Funeral Service Censee	1777	Warne and Address	CF Pecy	e Frage	raf Ser	DIR	
			23a. Part 1. Enter the disease, or complicat shock, or heart failure. List only one ca	use on each line.	not enter the mode of dying	, such as cardiac or	respiratory arrest,	NU ON	Approximate Interval Between	
Z	hysician/ Medical		Immediate Cause (Final disease or condition resulting in death)	ARUTE MYOCI	ARDIAL IN	SAFC T	してり		Onset and Death	
	Examiner	_	Sequentially list conditions, b. –	ARTERIZEC	LEKOTIC)	HEACT	- DICE	XJE	1 YEAR	
	ed	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury	Due to (or as a consequence of	of):			ļ		
	e executed cian and vurial-transit		that initiated events c. – resulting in death) Last	Due to (or as a consequence of	of):					
68760	cate be physic the bu	edic	d							
x 68	h certifi tending rr use a	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	If yes, outcome of pregnancy 1 □ Live Birth 2 □ Fetal death	a 3 ☐ Ectopic pregnancy	,		23d. Date of de		
Box	he deat y the at iched fo	hysic	1 Ves 2 No	4 Pregnant at time of death 9 Unknown	5 Other (specify)			Month	Day Year	
, P.O.	To the Hospital or Attending Physician: The law requires that the death certificate be within E4 hours after death certificate she within E4 hours after death. To the E4 hoursal Directors After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the but		Part II. Other significant conditions contrib	uting to death but not resulting i	n the underlying cause give	en in Part I.		/	the cause of death?	
Records,	require been s should	Completed by	XUPERTE	VSIDW COUNCE	17 15-1 177-1C	27 129113	1 ☐ Yes 2		robably 4 Unknown topsy findings available	
Rec	The law cate has page 2 s	Somp	HYPERLISI	DEMIA			autopsy performed? 1 \(\sum \) Yes 2	prior to death?	completion of cause of	
of Vital	sician; certific irector,	Be	25. Was case refe ed to medical examiner? 1 Yes 2 No Hosp	ital:	Other	ce of Death (Check o				
of \	ng Phy fter this ineral d	ate: To			ime of 28c. Injury 28c. Injury work?	at 28	e 5 Residence 3d. Describe how inju		ify)	
Division	Attendi r death. ctor: A y the fu	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	8e. Place of Injury - At home, far	M 1 🗆 Y	res 2□No	Bf. Location (Street a	nd Number or Ru	ral Route Number	
Divi	ital or / Ins after ral Dire led in b	al Ce	4 - Hornicide determined	building, etc. (Specify)			City or Town, Stat	e)		
	e Hosp 124 hou e Fune eleted fi	Medical	(Check 2 L Medical Examiner: (: To the best of my knowledge, on the basis of examination and/oactioner: To the best of my knowl	r investigation, in my opinior	n, death occurred at the	ne time, date and place	e, and due to the	cause(s) and manner stated.	
_	To th within	_	29b. Signature and title of certifier	Teall .	29c, License			ate signed (Month	n, Day, Year)	
	10 PB		30. Name and address of person who compl	eted cause of death (Item 23a)	MD D 2 Type, Print) BERN	ARD R	UFIN.N	2)///2	0/0	
			8600 LIBE	RTY KOA	D RAN	DAZLETO	wo no	21133	>	
	Stat Registra		31. Date filed (Month, Day, Year)	32. Registrar's Signature	barred					

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND ITEM#30perDVR, g899, 1/14/2010, WS
State of Maryland / Department of Health and Mental Hygiene State Registrar Reg. No Z Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 2010 1:03 p M Ernst Jr. Melvin January William Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Reisterstown 403 Academy Avenue Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Funeral Days Min. Hours 1 🛣 M 2 🗆 F Months 1 1-15-1956 Mary Land 53 Yrs Director Usual Residence of Decedent show 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Tant. If item 27 is marked other than "natural", or items 23a or 28a-f shoi ury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c, City, Town or Location Director 1 Yes 2 X No Baltimore Reisterstown MD 10f. Zip Code 10e. Street and Number 10g, Citizen of What Country? Funeral U.S.A. 21136 403 Academy Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 X Married 1 ☐ Yes If Yes, Give 2XXNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: Specify: 3 Divorced 4 Divorced White Year or Dates 16a Decedent's Usual Occupation 15 Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 years Carpenter Construction Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Marjorie A. Kenny William M. Ernst, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 403 Academy Ave. Reisterstown, MD 21136 Norma Jean Baker Ernst (wife) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1 a Department of h Important: If ite any injury or ot 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 1-11-2010 Carroll Cremation, Inc. |Hampstead, MD 4 Donation 5 Other (Specify) 21. Signature of June & Service Licensee 22. Name and Address of Facility 11824 Reisterstown 21136 J. Wayne Osterling Eline Funeral Home Reisterstown, MD Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest or hear failure. List only one cause on each line. 23a Part 1. Ente Approximate Interval Between Onset and Death Immediate Cause (Final UD Physician ev disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine trany leading to immedia cause. Enter Underlying Cause (Disease or iinjury for use as the burial-transi that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical 0 Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Month Year Pregnant at time of death 5 Other (specify) ed by the a detached f ☐ Yes 2 ☐ No 9 Unknown 9 Unknown s been signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by ① Yes 2 □ No 3 □ Probably 4 □ Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? certificate I 1 Yes 2 No 1 Yes 2 No Division of Vital director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? No Other: 4 Nursing Home 6 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 Inpatient 2 I After this within 24 hours after death.

To the Funeral Director; After this completed filled in by the funeral of 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending work? 1 ☐ Yes 2 ☐ No Natural Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, Seeth oribited at the time, date and place, and due to the stusies) and matters as 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2401 W. Belvedere Ave. Baltimore, MD 21215 Mae Pinkstaff Sally | 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible 20 10 0599 State of Maryland / Department of Health and Mental Hygiene

	State	e ?	31. Date filed (Month, Pay Nat 5 2010 32. Revistrar's Signature	_			OCME	~			
rA		3	30. Name and address of person who completed cause of death (Item 23a) Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimo	nore, MD 2	21201						
	2	2 2	29b. Signature and title of certifier O.C.M.E.				Date signed (Mornuary 10, 2010				
To the H within 24 To the Fe	Completely	3	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death and manner stated.	ath occurred a	t the time, date	and pla	ace, and due to the	e cause(s)			
Division lospital or Attend I hours after death uneral Director:			4 Homicide determined (Specify) house 29a. Certifier A Cartifician Devisions To the heat of pulsacular death constraint to the last of pulsacular death constraint and death constraint.		Baltimo	re,	MD				
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and	ched for use as t	וכומוי	past 12 months? 1 Live birth 2 Fetal death 3 Eco	ctopic pregna	incy		Month [ay Year			
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/Medic Examin	al		failure. List of ly one cause on each line Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):					Between Onset and Death			
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f she	injury or oth	L	Ardent Crem. 1 Burial 2 X Cremation 3 Removal from State Ardent Crem. 1/16/10 Hanover, MD								
re, ML s 1 and 2 s f Health au f item 27	or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Ermonel Director		Latierdra Sanders/Daughter 1659 E. Colds 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State Crematory or other place)	ery,	Date	20c.	Location - City or	Town, State			
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215-0036 be filed within 7 ntal Hygiene. rked other than	ent, the Mo				(First, Middle,		n Surname)				
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death with	nust be no	Funeral	11. Marrial Status 1 X Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic If Yes, specify Cuban, Mex			>-	14. Race - Amer White, etc. Afric	ican Indian, Black, an			
the Mary	Diroc.	2	10e. Street and Number 1515 N. Fulton Ave 21217			JSA	itizen of What Cou	ntry?			
land f show ar	2300		MD N/A Baltimore					1X Yes 2 No			
		-	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		3/2	. 7 0		10d. Inside City Limits			
Funer Direct			215 00 7714	f Under 24Hrs Hours Min	→	,	M/DD/YYYY) 9. Bir				
			4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Bon Secours Hospital 4c. County of Death N/A								
Phys ⊶dical Exa		1/	Decedent's Name (First, Middle,Last) Lisa R. Flack		2. Date of Dea Month January 9	Day	Year 10	3. Time of Death 1813 hrs			
		- 6	1- For State Certificate of Death		R	eg. No	D				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Farrell 5:00 A M 2010 January /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carroll Svkesvilla Ivansitions Health If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5 07 1927 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 156.20. Director Usual Residence of Decedent 10d, Inside City Limits 10a. State 10c. City, Town or Location is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified all Owings Mills MD 1 ☐ Yes 2 No Baltimore Director 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 1 Wellhaven Circle, Apt. 1215 21117 Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 □ No If Yes, Give 1 Never Married Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: Black 1 ☐ Yes 2 No Specify: Specify: \$ 3 Widowed 4 Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Ademico Security Co. ssembler 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be fi 1 and 2 should b Health and Ment 19a. Informant's Name/Relationship (Type, Prin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21117 Wellhaven Circle, Apt. 1215 permit. Pages 1 and 2 :
Department of Health ar
Important: If item 27 is
any injury or other trau Owings Mills, MD 20c. Location - Gity or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Owings Mills, MD tovest on C. Greenk Funeral SICS 21. Signature of Funeral Service License Randalistown MD2133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart ailure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** SEP 515 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Jacob Chesta of Injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine requires that the death certificate be execu burial-trar Due to (or as a consequence of) attending physician Physician/Medical the IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4 ☐ Pregnant at time of death 5 Other (specify) ☐Yes 2☐No the Division of Vital Records, P.O. 9 Unknown 9 ☐ Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. FMENTIA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2 🛂 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After the Hospital or Attending I hin 24 hours after death. the Funeral Director: After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title certifier 29c. License number 2010 P57722 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1838 GREENE PILESVILLE MA ZIZUS ROAP #300 LEONARD RICHARDSON M. D > 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month **Physician** 12, Fenloch Jr. 2010 15:40 January Anthony 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 8116 Dundalk Avenue Dundalk If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) June 18,1951 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Months Days Hours Maryland 1X M 2□ F 58 215-58-4545 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 □Yes 2 TWO Director Baltimore Dundalk Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21222 8116 Dundalk Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☒No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 □Yes 2 XI If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 ☐ KNo Specify þ, 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Plumber Plumbing 12 years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Marcella Kirby Harry Fenloch Sr. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7048 Dunhill Road, Dundalk, Maryland 21222 Scott Fenloch son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition January 18 1 ☐ Burial 2 🛛 Cremation 3 ☐ Removal from State Bayview Crematory Baltimore, Maryland 2010 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses ^{22 Name and Address of Facility} I Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 21222 23a. Part 1. Enter the disease, or complications that caused the death. To not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final relanone metristati MONTHS disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 □Yes 2 □No 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ž No 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 □ Yes 2) 🗷 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ≥ZNo 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d Describe how injury occurred 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 6 ☐ Accident 6 □ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Division of Vital Records, P.O. Box 68760, physician the as attending properties as ned by the ate has been signed page 2 should be det certificate within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

/Medical

Funeral

Director

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permit. Pages 1 and 2 should be filed within 72 hours after d Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item any injury or other traumatic event, the Midical Explainment once.

Physician

/Medical

Examiner

Baltimore, Maryland 21215-0036

Physician/Medical <u>δ</u> Completed Be Certification: To

State

Registrar

Medical

and manner stated

29c. License number O 38100

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Falls Rd #415 Lamalla MO 21093

1275 Shairm

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31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

29a, Certifier

32. Registrar's Signature

DHMH 17 Rev 1/2001

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. Ne 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** lowers 550 2010 /Medical anuaco 11 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Baltimore Good Samaritan Hospital If Under 1 Year If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** 1 M 2 F Months Days Hours 241-14-7877 UNKNOWN Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any follury or other traumatic event, If a Modifical Exymetric must be rediffed at any logics. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 Nes 2 No Completed by Funeral Director altimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 1 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □ Yes 2 No If Yes, Give Year or Dates: Black Specify: 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Şecondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ၉ nown 19a. Informant's Name/Relationship (Type., Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Spenty) 21. Signature of Funeral Service License tome 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Se que d'ally list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Box 68760 Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 X No Day Month Year 5 Other (specify) P.O. After this certificate has been signed by the a funeral director, page 2 should be detached 9 Unknown 9 Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □No 24a. Was an 2/2 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 □ DOA Medical Certification: To 1 Inpatient Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 2 Accident 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pendina 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A investigation 6 ☐ Could not be Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) Mr) Schubles KEVIN 5601 Loch Raven Boulevard, Baltimore Maryland 21239 32. Registrar's Signature 31 Date filed (Month, Day, Year) State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 9, 2010 Year Physician/ 7:54 PM MARY ESTHER STUART FOUTZ January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore County GILCHRIST HOSPICE CENTER Towson If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 □ M 2 🔯 F 94 Months Hours May 16, Year) 915 Mary Land Director 217-12-9151 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director 1 Yes 2 X No Maryland | Baltimore County Towson 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code ō Funeral 23a 7819 Overbrook Road 21204 USA permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item any injury or other traumatic event. The status of the s 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. þ 1 Never Married 2 Married ☐ Yes 2 🏻 No 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: White 3 X Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Residence Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ **GLENN** STUART LOUISE BELCHER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7819 Overbrook Road, Towson, Maryland 21204 David S. Foutz (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) 1/12/2010 Baltimore, Maryland Cemetery Green Mount 2MTTCHELL WIEDEFELD FUNERAL HOME, INC.
Religious, Maryland 21212 21. Signatur of Funeral Service License Martin D. Lawson 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ementa disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last ttending physician or use as the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23h Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Year Day Pregnant at time of death signed by the 9 Unknows Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 3 Probably 4 Unknown Division of Vital Records, 24a. Was an 24b. Were autopsy findings available prior to completion of cause of Jas autopsy death? 1 ☐ Yes 2 ☐ No Yes Director: After this certifical in by the funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 No Other: Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide injury work?
1 Yes 2 No 5 Pending Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in my called 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) Signature 29d. Date signed (Month, Day, Year) 2010 anvaru

DHMH 17 Rev 7/2009

State Registrar Awen

31. Date filed (Month, Day,

6701

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Jerome Andre Fuller, Jr. State of Maryland / Department of Health and Mental Hygiene 1 - For State Certificate of Death Reg. No Registra 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ 3 Time of Death January 8, 2010 2220 hrs Medical Examine **JEROME** ANDRE FULLER JR. 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death 376 Possum Court Capitol Heights Prince George's 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Gounty shington Months Days Hours Director 577-02-4764 1XXM 2 F 33 7-21-1976 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County 1 X Yes 2 No or 28a-f show MD PRINCE GEORGE'S TEMPLE HILLS other than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at once, ретиіг. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3328 27th AVE 20748 UNITED STATES Funera 12. Was Decedent Ever in U.S 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Never Married 2 Yes 2 X No Yes, Give Year 1 Yes 2 X No specify: 4 Divorced Specify BLACK <u>م</u> 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed Elementary/Secondary (0-12) College (1-4 or 5+) 12 VENDOR PRIVATE is marked other 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) JEROME ANDRE FULLER Be VICTORIA HILI ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) VICTORIA HILL-PUGH/ MOTHER If item 27 3328 27th AVE TEMPLE HILLS MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State timore, crematory or other place) 1 K Burial 2 Cremation 3 Removal from State Harmony Cemetery 1-16-2010 Landover MD Donation 5 Other Specify 5 21. Signature of Funeral Service License 22. Name and Address of Facility Washington Pope Funeral Homes 2617 Penn Ave SE DC 20020 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval Between Onset and failure. List only one cause on each line /Medical Death a Multiple Gunshot Wounds Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transi Physician/Medical attending physician or use as the burial -UNPENDED **AMENDED** Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Month Day Year Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) that the death 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions o contributing to death but not resulting in the underlying cause given in Part I. é ے 1 Yes 2 No 3 Probably 4 Unknown Completed Records, 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of The law i has performed death? this certificate ✓ Yes 2 No 1 🗸 Yes 2 No 26.Place of Death (Check only one) Physician: 25. Was case referred to medical Division of Vital Be Hospital: 1 Inpatient 2 Other Nursing Home 5 Residence 6 Other Scene ER/Outpatient 3 DOA 1 Yes No After 28a Date of Injury 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? To the Hospital or Attending within 24 hours after death. Jan 8, 2010 Subject shot Natural 2212 hrs 1 Yes 2 ✔ No Pending Director: the Accident Investigation in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) 376 Possum Court, Capitol Heights, MD determined (Specify) Parking Lot 4 V Homicide To the Funeral 29a Certifier 1 [Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number

State Registrar

31. Date filed (Month, Day, Year)

Carol Allan MD

30, Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

OCME

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

January 9, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 0 00605 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 4:05am M January 2010 William Stanton Frank Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner **Baltimore** Greenview Avenue <u>Reisterstown</u> If Under If Under 24 8. Date of Birth Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🖾 M 2 🗆 F Months Days Hours Min. Nov 17, 1947 Maryland Yrs. **Director** 212-50-4163 62 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No MD Baltimore Reisterstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral U.S.A. 36 Greenview Avenue 21136 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Orlgin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 X Married X Yes 2 🗌 No Maryland 21215-0036 1 Yes 2 No Specify. If Yes. Give Specify: 3 Widowed 4 Divorced Year or Dates. White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Lineman Crew Leader BGE 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) and Mental H မ George Frank Ruth Ann Murray 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) it of Health : 36 Greenview Avenue Reisterstown, MD 21136 <u>Sharon Frank</u> Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Department o Important: If any injury or ō Garrison Forest Cem 1/20/10 Owings Mills, MD f Juner Service Licensee 22. Name and Address of Facility 11824 Reisterstown Road 21. Signatu J. Wayne Osterling ELINE FUNERAL HOME Reisterstown, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Glioblastma disease or condition resulting in death)) Medical Due to (or as a consequence of) Examiner Sequentially list conditions ner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Examir as the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ the Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 🗌 No Yes 2 XN 1 Tyes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 No 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA this completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural After Pending 1 ☐ Yes 2 ☐ No Accident Investigation ofter death Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined e Funeral Medical **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) ٥ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) harlosm

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State Registrar 31. Date filed (Month, Day, Year)

MD 6095 Marsha

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ JANÜARY LESTER FEIT 2010 5:35P [™] Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death GILCHRIST HOSPICE CARE BALTIMORE Funeral Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 🛛 M 2 🗆 F Hours Country) 0572071918 91 Yrs. Director 218-05-5828 MD Usual Residence of Decedent "natural", or items 23a or 28a-f shov edical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location within 72 hours after death with the Maryland Director 10d. Inside City Limits MD 1 X Yes 2 □ No N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3304 CLARAN ROAD 21215 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Completed by 21215-0036 1 ☐ Yes 2 🛣 No Specify: 3 X Widowed 4 Divorced Specify: WHITE Year or Dates injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Seconday (0-12) College (1-4 or 5+) filed within all Hygiene. OWNER OPERATOR MOVING & STORAGE Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental H permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marker any injury or other traumatic ~ DAVID FEIT BERTHA FRIEDMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SHARRYN GREENBERG / DAUGHTER JANELLEN DRIVE, BALTIMORE, MD 21208 Baltimore, 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State HAR SINAI CEMETERY 4 Donation 5 Other (Specify) 1/13/2010 OWINGS MILLS, MD 21. Signature of Juneral Service Licer 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Inset and Death Immediate Cause (Final Physician/ a disease or condition Medical resulting in death) Examiner r as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) executed attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death 5 Other (specify) certificate has been signed by the irector, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ Completed 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 25. Was case referred to medical director, æ 26. Place of Death (Check only one) examiner? 1 Yes ျ 2 🕅 No 4 ☐ Nursing Home 5 ☐ Residence 1 Inpatient 2 ER/Outpatient 3 IDOA Certificate: 27. Manner of Deat 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 28d. Describe how injury occurred 1 Natural 5 \square Pending injury 2 🗌 No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) the Hospital 24 hours Medical within 24 hor To the Fune completed fi 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, in my opinion of eath occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗌 only one 29b. Signature and title of certifier

State Registrar

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701 N Charles SI

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death L 3, 2010 **Physician** Month 715 Shawn P. Gover Sr. January /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death **Examiner** maryland General Baltimore 5. Social Security 14 ppe 218-17-870 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days Hours XXM 2 F **Director** MD Oct. 24, 1977 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ortant: If Item 27 is marked other than "natural", or Items 23a or 28a-f show Injury or other traumatic event, if a Medical Examinat must be notified at MD Baltimore City Funeral Director 1X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2051 Druid Park Drive 21211 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 1 ☐ Yes ZXNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 □Yes XXNo Completed by Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Self Employeed Handy Man Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be finent of Health and Mental Int: If Item 27 is marked o William Gover 0 Linda Catron 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Amanda Gover 2051 Druid Park Drive, Baltimore MD 21211 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Ite
any Injury or ot 1 ☐ Burial XXCremation 3 ☐ Removal from State 4 □ Donation Glen Burnie,MD Atlantic Crem. Jan.7,2010 5 ☐ Other (Specify) 22. Name and Address of Facility f Fineral Service Licensee 2829 Hudson St., Baltimore MD Skarda F.H. 21224 Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complications that caused the deathf. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** neumoco disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner 2 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the Hospital or AttendIng Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Year Day 5 Other (specify) 1 ☐Yes 2 ☐No detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cate has been sign page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate 1 ☐Yes 2 ☐No 1 ☐ Yes funeral director, 25. Was case referred to medical example? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 □Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death laryland Guneral Hospital e tha Jomashe 31. Date filed (Month, Day, Year) State MAN 15 2010 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year GROSS-HALL Month **Physician** VICTORINE 11: 22 AM JANUARY 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE NORTHWEST HOSPITAL RANDALLSTOWN If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, OCT, 14 Birthplace (State or Foreign Country) 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Days Min 1 □ M 2 😿 F Director Sylvania Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location r than "natural", or items 23a or 28a-f show the Medical Exerciper must be notified at 1 XYes 2 □ No Director VICE. MOTE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 🕱 No 2 Specify: 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Şecondary (0-12) College (1-4or 5+) Department of Health and Mental Hygis Important: If item 27 is marked other any injury or other traumatic event, II once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be f ment of Health and Mental 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) (daughter Bernaa Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Son 4 Donation 5 DOther (Specify) Wings 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Home P.A. 21216 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** INFARCTION MYOCARDIAL disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner UNKNOWN CORONARY ARTERY DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): or Attending Physician; The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): P.O. Box 68760, attending physic for use as the b IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) detached 9 Unknown s been signed b should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown DIABETES MELLITUS 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 s autopsy certificate ! 1 □ Yes 2 No 1 🗌 Yes 2 X No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 3 ☐ Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

Division of Vital Records,

within 24 hours after death To the Funeral Director: completely filled in by the

State

Medical

MURTUZA 31. Date filed (Month, Day, Year) IAN 15 2010

(Check only one) 29b. Signature and itte

> AHMED M.D.

5401

OLD COURT ROAD

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D0060293

JANUARY

KANDALLSTOWN, MD

30. Name and address of pason who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

32. Registrar's Sig

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year itus, Weihman, Green 0740 A M January Medical 4c. County of Death N/A 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Johns Hopkins Baltimore Bayview Medica 5. Social Security Number 7. Age (In yrs. last birthday) 79 yrs. If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 D F Min. 5/26/30 Year Months Days Hours Country) 247-38-1628 Director Usual Residence of Decedent shov 10a. State 10b. County 10c. City, Town or Location with the Maryland item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director MD N/A Baltimore Y Yes 2 No 10f. Zip Code 21229 10e. Street and Number 10g. Citizen of What Country? Funeral 726 Lyndhurst St. USA Page 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. vvas Decedent Ever in U.S. Armed Forces? 1 ■ Yes 2 □ No If Yes, Give 1 950-2 Year or Dates. 14. Race - American Indian Black, White, etc.
African
Specify: þ 1 Never Married 2X Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Completed American 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) of Health and Mental Hygiene. Trucking Elementary/Seconday (0-12) College (1-4 or 5+) Driver Be T. Father's Name (First, Middle, Last) Frank Green, Sr. 18. Mother's Name (First, Middle, Maiden Surname) Henrietta Sally Green 19a. Informant's Name/Relationship (Type, Print)
Maggie H. Green/Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 726 Lyndhurst St., Balt., MD 21229 20b. Place of Disposition (Name of cemetery, crematory or other place)
Garrison Forest VA 20a Method of Disposition 20c. Location - City or Town, State Department of I-Important: If ite any injury or ott 1 M Burial 2 Cremation 3 Removal from State 1/22/10 Owings Mills, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Hari P. Close F. Svs, PA 21. Signature of Jun ral Servic Licensee 5126 Belair Rd, Balt., MD 21206-5105 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician Due to (or as a consequence of): disease or condition resulting in death) One week Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): burial-transi Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical that the death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ Live Birth 2 Live Birth 2 Pregnant at time of death in the past 12 months?

1 Yes 2 No Month signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, The law requires icate has been sig 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a, Was an autopsy performed' death? To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 🗌 Yes 2 No 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) m D 00067118 12. 2010 anuar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mary Westergaard M.D. 4940 Eastern Ave, Baltimore, MD 21224

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day,

32. Registra s Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ *10*4M Medical Town, or Location of Death 4c. County of Death Examiner last birthday 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🔀 Director ms 23a or 28a-f shor must be notified at 10a. State City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Funeral Director 1 Yes 2 ☐ No 10e. Street and Number 10g. Citizen of What Country? 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) the Medical Examiner Never Married 2 Married White, etc. ö ģ Baltimore, Maryland 21215-0036 1 🗆 Yes 2 📉 No Specify: "natural", Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ulth and Mental Hygiene.
27 is marked other than "ir traumatic event, the Mec donday (0-12) College (1-4 or 5+) Be 17 Father's Name (First, Middle, Last Health a tem 27 i permit. Page 1 and 2 Department of Healtt Important: If item 2 any injury or other tonce. Method of Disposition 2' 3. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signatur f Fu. r Servi e Lio nsee 23a. Part 1. Enter the disease, or complications that caused the death. Do not ente shock, or heart failure. List only one cause on each line. 4 Immediate Cause (Final disease or condition Onset and Death Embolism Physician/ Mulmonary Medical resulting in death) Due to (or as a consequence of) Examiner 5 weeks Thoracic acrtic Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Be Completed by Physician/Medical Examine Due to (or as a consequence or) Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of) After this certificate has been signed by the attending physician funeral director, page 2 should be detached for use as the buria Division of Vital Records, P.O. Box 68760 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Pregnant at time of death Day Year 4 Pregnant 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗆 No 1 Yes 25. Was case referred to medical the funeral director, 26. Place of Death (Check only one) Other: 2 WNo မ 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Naturai (Month, Day, Year) iniury 5 Pending after death. 1 Yes 2 No Accident Investigation 6 Could not be To the Hospital or Atte within 24 hours after de To the Funeral Directo completed filled in by the Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 00062074 MD nula 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Surte 300 21201 MD KHAMBAT Greeke 31. Date filed (Month, Day, Year) Registrar's Signature State JAN 1 4 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ 12:28P Jane Barbara Gisriel January ,2010 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death Examiner 4c. County of Death Balto. Gilchrist owson 8. Date of Birth (Month, Day, Year, August 28 If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Months Hours Min. 1 □ M 2X□ F Maryland Director 219-22-8831 Usual Residence of Decedent or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2x ☐ No Glen Arm Md Balto. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21057 IISA 11630 Glen Arm Rd. Ste.306 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Completed by 1 Never Married 2 Married 1 Yes : Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify: 3 XWidowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Telephone Company Management Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Julianna Janeczek Zastawski Casimir 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DTR. 1304 Bennett Place BelAir, Md. 21015 Teresa J. Nos 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐xBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1-16-2010 Balto. Md. 0aklawn 21. Signature of Funeral Service Licensee Schimunek Funeral Home 22. Name and Address of Facility Nottingham, Md. 21236 9705 Belair Rd. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying aftending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month signed by the a d be detached f g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed certificate has been si irector, page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certifical completed filled in by the funeral director, it Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 2 No 은 1 Inpatient 2 ER/Outpatient 3 DOA 6 Other (Specify) WOSPI W Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 \square Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 3 🗆 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 13 2010 ENVER 4 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHAPLES 6701 N. Chances ST 31. Date filed (Month, Say, Year) State 4 201 Registrar

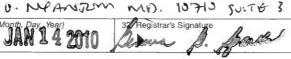
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** GREENE MA 9.48 PM 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** HOWARD COUNTY GONERAL HOSP HOWARD Corumsia If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) October 24,1933 **Funeral** Days Hours 1 □ M 2 🛣 F Months 213-30-0429 Maryland Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Wedical Examiner must be marified. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 ☐ No Directo Marvland Columbia Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9334 Big River Run 21045 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔼 No Specify: þ Specify: 3 Nidowed 4 Divorced **Black** Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ambrose David Cross Gladys Stanton 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ambrose Greene 8535 Dark Hawk Circle Columbia, Maryland 21045 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crestlawn Memorial Garden 1-15-2010 Marriottsville, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Witzke Funeral Homes, 5555 Twin Knolls Road Inc. Columbia, Maryland 21045 23a. P. t1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, slock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** SEPTIC SING CIC HOVRI /Medical Due to (or as a consequence of): Examiner UBSTRUCTION Smore Rower INVERS Sequentially list conditions, if any, loading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Division of Vital Records, P.O. Box 68760. Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ MESPIRAZINY 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed RENM GATIRE 24b. Were autopsy findings available prior to completion of cause of death? performe WHILE WOODS WY 1 □ Yes 2 **(V**) i or Attending Physician: after death. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manyrer of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No eral Director: / 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital of within 24 hours af To the Funeral Discompletely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical (Check only one)

State Registrar 31. Date filed (Mon

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier



29c. License number

D36974

29d. Date signed (Month, Day, Year)

2010

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Janh ary 1235PM MARGARET ELIZABETH GOODMAN 2010 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death Examiner 4c. County of Death len Burni Anne Baltimore Washington Med Ctr If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗹 F Davs (Month, Day, Months Hours 99 Director 196-10-5918 Pennsylvania Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10c. City. Town or Location 10d. Inside City Limits Director 1 Tyes 2 Yo MD Anne Arundel Pasadena 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 222 Wanda Road 21122 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: If Yes, Give Year or Dates Specify: White 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working should be filed within 72 h and Mental Hygiene. 7 is marked other than "r life. DO NOT use retired) Department of Elementary/Seconday (0-12) College (1-4 or 5+) Clerk Social Security Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ other traumatic George William Buchner Laura Catherine Snyder 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lege 1 and 2 s.
Legatment of Health ar.
Important: If item 27 is r.
any injury or other Halethorpe, MD 21227 <u>Lvnn Gurtler / Daughter</u> Grevstone Road. 3altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 101/16/10 Glen Burnie, MD <u>Glen Haven Mem Pk</u> 21. Signature of Europal Service Censee 22. Name and Address of Facility G.J. Gonce Funeral Home, Riviera Drive, Pasadena, MD 21122 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause Immediate Cause (Final vn) Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sanuartieth list erecttions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): sician and burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): physician a Physician/Medical 68760 attending p IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav Year Pregnant at time of death the detached Unknown þ signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> Records/ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed Yes 2 within 24 hours after death.

To the Funeral Director. After this certificate homeleted filled in by the funeral director, pag 1 🗌 Yes 2 No of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: ၉ 1 hpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury_at 28d. Describe how injury occurred Hospital or Attending 1 Natural 2 Accident 3 Suicide 5 Pending 1 Tyes 2 🗌 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature an 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) State Registrar DHMH 17 Rev 7/2009

ORIGINAL

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3

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

DHMH 17 Rev 1/2001

within 2.

State Registrar

31. Date filed (Month, Day, Year)

of person who

29b. Signature and title of certifier

(Check only one)

32. Registr

Mn

pleted cause of death (Item 23a) (Type, Print)

Telefthying Physician: to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

027569

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year George Hill 5:20 P.M 2010 Medical Januarv 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carroll Westminster Dove House 5. Social Security Number If Under 1 Year If Under 24 Hrs. Sex 1XXM 2 □ F 7. Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. (Month, Day, Year) ec. 13, Country) North Director 219-34-2412 Dec. .938 Carolina Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Direct 1 Yes XX No Maryland Carroll Manchester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country United States Funeral 4228 Hanover Pike 21102 America Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in_U 14. Race - American Indian. Armed Forces? 1961 Black, White, etc. <u>Ş</u> 1 Never Married 2XX Married hours after 2 🗌 No Maryland 21215-0036 1963 1 ☐ Yes 2XXXNo Specify: If Yes, Give Specify: White "natural" Completed 3 Widowed 4 Divorced Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) 72 than Elementary/Seconday (0-12) College (1-4 or 5+) should be filed within and Mental Hygiene. 9th Pipe Layer Construction marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ John Hill Elizabeth Whitson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) .00 1 and 2 s of Health item 27 <u>Janet A</u>. Hill (Wife) 4228 Hanover Pike, Manchester, Maryland 21102 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Jan. 14, permit. Page 1 a Department of H Important: If ite any injury or ot 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Metro Crematory 2010 Catonsville, Maryland of Funeral Service Licen 22.Name and Address of Facility Eckhardt Funeral Chapel, P.A. 3296 Charmil Drive, Manchester, Maryland 21102 1. Inter the disease, or complication used t death. Do not enter the mode of dying, suc as cardiac or respiratory arrest, Approximate Interval Between Onset and Death or heart failure. List only one cau Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine f any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trans resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death Other (specify) signed by the a 2 🗌 No 9 Unknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 🗌 Yes cate has been signated bage 2 should b 2 🗌 No 3 Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No perforn certificate Yes director, **Division of Vital** Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? DOVE Hux 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 \square Pending injury work? 1 ☐ Yes 2 🗀 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examin (Check er: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one Certifying Nurs ctioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. title of certifier 29b. Signature 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 7/2009

State Registrar 30. Name and

ddress of person who

			For State	State o	of Marylar					Mental Hy	gien	e 201	Ω	00616
			Registrar 1. Decedent's Name (First, Middle,	Last)		Cer	tificate c	n Dea	un	2. Date of De	Reg. N	10. C U 1	U	00010
	Physicia		Virginia Mays H	· ·						Month	0		ear	3. Time of Death
-	Medic Examin		4a. Facility Name (if not institution,			-	4b. City, Tow	n. or Loca	ation of Deat	<u> Januar</u> h		3 , 201 c. County of I		8:00 P. ^M
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	Funeral			6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Y		Under 24 Hrs	8. Date of Bir	th	9	. Birthp	lace (State or Foreign
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	ld now	_	Usual Residence of Decedent 10a. State 10b. County		10c Cit	ty, Town or Loc	cation						1/	Od. Inside City Limits
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	or 28	Ë	Maryland Carr 10e. Street and Number	011		Manc	hester	de			10a. (Citizen of Wha	nt Count	
	with t	eral	3032 Wertz Aven	110				2110	12		Uni	ted St	ate	
	eath tems er mu	Funeral Director	11. Marital Status	12. Was Dece	dent Ever in U.	S. 13. V	Vas Decedent	of Hispan	nic Origin? (S	pecify Yes or No-	OL	Americ 14. Race -		an Indian,
39	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f show , the Medical Examiner must be notified at	Completed by I	1 Never Married 2 Marri 3 Nidowed 4 Divorced	Armed Fo 1 Yes If Yes, Giv Year or Da	е		Yes, specify C			o Hican, etc.)		Black, \ Specify:	_{White, e} Whit	
Ö	2 hours aft "natural", edical Exal	lete	15. Deceden	t's Education			lent's Usual Oc				16b.	Kind of Busin		
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7	led within Hygiene. other tha ent, the N		11th				Superv	rișor	•			Caf	etei	ria
nd	요수 후 등	To Be	17. Father's Name (First, Middle, La	ast)						me (First, Middle,		n Surname)		
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Mai			19a. Informant's Name/Relationsh		1		_			ıral Route Numbe				
	and Heal em 2		William R. Hale 20a. Method of Disposition	(nuspano		Place of Dispo				nchester		aryıan Location - Cit		
nor	Page 1 nent of ant: If it ury or o		1XXBurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S)		State	cemetery, cren	natory or other	place)		n. 16,			•	
Baltimore,	# # 4 #		21. Signature of Fig. 13 Service Li		Inev	V Luthe				010				Maryland
ä	permi Depar Impor any ir	1	MANN OCHMI	ant -		Ec 32	khardt 96 Chai	Fune cmil	eral Cl Drive	napel, P <u>, Manche</u>	.A. ste	r, Mar	yla	nd 21102
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	Physician/		I mediate Cause (Final sease or condition resulting in death)	_a_ \\	MOV	MC	15 4	Ju C	av vi	ne lell Co			1	Onset and Death
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Box 687	ath certifica attending p	jan/	23b. Was decedent pregnant in the past 12 months?	1 🔲 Live	come of pregna Birth 2 🗆 Feta	al death 3 🗌						23d. Date o		•
	e deal the at hed fo	Physician/M	1 ☐ Yes 2 🗹 No 9 ☐ Unknown	4 ☐ Preg 9 ☐ Unkr	nant at time of a nown	death 5 ∟	Other (specify	v)				Month		Day Year
P.O.	that the dea led by the a detached f	by Ph	Part II. Other significant condition	ns contributing to d	eath but not res	sulting in the u	nderlying caus	e given in	Part I.	23e. Did to	obacco	use contribu	te to the	e cause of death?
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₹	hysic his ce I dire	To	1 ☐ Yes 2 ☐ No	Hospital:	Inpatient 2	ER/Outpatien	t 3 🗆 DOA	Other: 4	☐ Nursing H	Home 5 Resid	dence	6 Other (S	pecify)	
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ior	ttend death tor: A	tific	2 Accident Investig	ation	-61-1				2 No	lance of the second			-	
Division of Vital Records,	al or A s after I Direct I in by		4 □ Homicide determi		of Injury - At hong, etc. (Specif)		et, factory, on	ce		28f. Location (S City or Tox			r Hurai i	Houte Number,
_	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi	Medical	(Check 2 Medical Ex	Physician: To the b	is of examinatio	n and/or invest	igation, in my o	pinion, de	eath occurred	at the time, date a	and plac	e, and due to	the caus	se(s) and manner stated.
	To the within to the somple	Σ	only one) 3 L Certifying 29b. Signature and title of certifier	Nurse Practioner:	Io the best of m	y knowledge, d		at the time ense num		ace, and due to th		(s) and manne ate signed (M		· ·
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			30 Name and address of person w	ho completed caus		1 23a) (Type, P	rint) 7_	1 9	Па.	c2 1.	21	2 1	_	40 W.7
			31. Date filed (Month, Day, Year)	1 stain	M. N.	441) 04	71-1	can	>1 / W	T-1	mersu	v '	0 0000
	Stat Registra			5 2010	edistrar's Signa	A. A	barker	,						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2 Date of Death Year Month **Physician** ALICE **JOYCE** HAWKINS 10:42PM January 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner St. Agnes Hospital Baltimore. Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Feb 24, 1938 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2/X Months Maryland 213-36-9414 71 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10b County 10c. City. Town or Location ral", or Items 23a or 28a-f show Examiner rust be notified at 1 □Yes 2 📈 💢 Directo Maryland Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 2 lightly or other traumatic event. The Wedical Evantines must hereponee. 5348 Frederick Avenue 21228 USA Funeral 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status XX Never Married 2 Married Baltimore, Maryland 21215-0036 2 1 ☐ Yes 2 📉 No Specify: Specify. White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Assistant Treasurer Banking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Thomas Augustus Hawkins Mary Burnett Wilkinson ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Faith Hawkins Welsh Sister 4115 Tulare Drive Silver Spring MD 20906 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 16.2010 1**XXX**Burial 2 □ Cremation 3 Removal from Timonium, Maryland Dulaney Valley Mem Gardens Donation 5 Other (Specify) 22. Name and Address of FaMiltchell-Wiedefeld Funeral Home Inc anature of Funer 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the disease or complication shock, or heart failure. List only one call s that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death ise on each line. Immediate Cause (Final **Physician** tured disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-transi P.O. Box 68760 Due to (or as a consequence of) physician the burial Physician/Medical ending p IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant atter for u 3 🗆 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☑ No 9 ☐ Unknown been signed by the a should be detached f 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performe certificate 2 **/**No 2 🗷 No 1 □ Yes or Attending Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1□Yes 2⊅No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this nours after death.

neral Director: After this
y filled in by the funeral di 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide the Hospital 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical within 2 To the I and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

alvin

31. Date filed (Month, Day, Year)

AVENUE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

David

900

Caton

632: Registrar's Signature

P23574

January 12, 2010

Baltimore MD 21229

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month ELIZABETH L. HUCIK 4:30 PM 201 Medical 4a. Facility Name (if not institution, give street and number 4c. County of Death 4b. City, Town, or Location of Death Examiner timore Frank a Mari 7. Age (IM yrs. last birthday) If Under 1 Year If Under 8. Date of Birth 9. Birthplace (State or Foreign Sex **Funeral** 1 🗆 M 2 🖵 F Months Days Hours Min. April 9 216~30~2177 73 Marvland Director Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location event, the Medical Examiner must be notified at 10d. Inside City Limits Director Baltimore County 1 Yes 2XXNo Baltimore Maryland 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? 23a Funeral USA 21236 4221 Darleigh Rd. items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any Injury or other traumatic event, the Medical Examin ð 1 Never Married 2 Married Yes XX No If Yes, Give Year or Dates 1 ☐ Yes 2XX No Specify: Specify: White Completed 3 Widowed 4 Divorced 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Restaurant Business Sales Person 9th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ethel Earhardt John G. Saffell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4221 Darleigh Rd. Baltimore, Md. 21236 Louis S. Hucik (Husband) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) XX Burial 2 Cremation 3 Removal from State St. Joseph Ch. Cem. 1-16-2010 |Fullerton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Vicensee 22. Name and Address of Facility 7401 Belair Rd. Lassahn Funeral Home 21236 Baltimore, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Chysician disease or condition resulting in death) ronar Medical Due to (or as a consente ce of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury (dr as a consequence of): the burial-transi Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last as a consequence of): physician Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 - Ectopic pregnancy in the past 12 months?

1 Yes 2 No ģ 4 Pregnant 9 Unknown 5 Other (specify) Month Day Year Pregnant at time of death signed by the a Yes 1 ☐ Yes 23 9 ☐ Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an within 24 hours a er death.

To the Funeral Director: Af er this certificate has completed filled in by the funeral director, page 2 autopsy 1 Yes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 🛣 No Division of Vital Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 2 No 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c, Injury at work?
1 Yes 2 No Certificate: 28d. Describe how injury occurred 1. Natural injury 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) Medical 29a, Certifier 1. 💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death ((Type, Print) 5

DHMH 17 Rev 7/2009

State Registrar edistrar's Sid

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death THUMNY Physician/ HOWE 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BON BALTIMOR SECOVES 1405PIRE If Under 1 Year If Under 24 Hrs. . Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Funeral Month, Pay, 1 X M 2 □ F **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iteme ?? 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director 1 X Yes 2 ☐ No more 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married 1 ☐ Yes 2 🕅 No Specify: If Yes, Give Year or Dates. 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired), 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17401 (SON) 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2010 4 Donation 21. Signature of Feneral Service Lice see 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ SHOCK SEPTIC disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner 1 BOOM INDE WOUND INFECTED Sequentially list conditions, if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or iinjury that initiated events mouth COLOSTONY 1680STON the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last men the Physician/Medical 115ccs1 1890 MILM Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Month Day Yes 2 No 1 ☐ Yes 2 ☐ Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e Did tobacco use contribute to the cause of death? Completed by 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 1 🖺 Yes funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe SPLENECTON certificate 1 🗌 Yes 2 🗆 No Yes Be (25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 2 - No ၉ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \square Homicide determined within 24 hours a To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) D1805 2010 who completed cause of death (Item 23a) (Type, Print)

Registrar

PELATO

CORREA /

SEROMS

MOSPITAL

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND TTEM# 5P ERFH, G901, 3747, 2010, WS

State of Maryland / Department of Health and Mental Hygiene. 00620 1 - For State Registrar Certificate of Death Reg. No.-3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **2**\bar{0}a0 **Physician** Harris Tanuary Linwood /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BA Him OLE

IT 1 Year | If Under 24 Hrs. | 8. Date of Birth

Days | Hours | Min. | 8 / 27 / 23 Raven Community Living Center 9. Birthplace (State or Foreign Sex 1ÅM 2□F 7. Age (In yrs. last birthday) 87 yrs. **Funeral** VΑ Director Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mertal Hyglend. Instituted to the state of the state o Baltimore MD N/A 1XYes 2 □ No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2609 Cecil Ave USA 21218 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married African 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 ₩ Widowed 4 Divorced Year or Dates American Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Railroad Engineer 11 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be unk Zina Harris ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2609 Cecil Ave, Balt., MD 21218 Shawn N. Harris/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Garrison Forest VA 1/21/10 1 DeBurial 2 ☐ Cremation 3 ☐ Removal from State Owings Mills, ND 4 ☐ Donation 22. Name and Address of FacilityHari P. Close F.Svs, PA 21. Signature of Euneral Service Lice 5126 Belair Rd, Balt., MD 21206-5105 Approximate Interval Between Onset and Death complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest 23a. Part 1. Inter the disease of complications that caused the shock, or heart failure. List only one cause on each line. Immediate Cause (Final Metostatic olon **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to the district cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Month Day Year 1 ☐Yes 2 ☐ No the detached 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □No 24a. Was an autopsy performed Yes 2 No the Hospital or Attending Physician: completely filled in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 HOther (Specify) Rehab Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 No 1 ☐ Yes Certification: To this 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manyor of Death 28c. Injury at Work? 1 V Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death Funeral Director: 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 🚩 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) within 2 Jenuary 10, 2010 Wills I M.D. cks VI M.D. 3900 Loch Raven Bonlevard, Battimore, MD istrar's Signature State Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygienes Are Legible.

			for State Registrar	Otate of Maryland / E	Certificate of Deat		2010	00621
F	Physici		1. Decedent's Name (First, Middle, Las		Harris		Day Year	3. Time of Death
1	/Medio Examin		4a. Facility Name (If not institution, give	street and number)	4b. City, Town, or Location		c. County of Death	1023
F	uneral		5. Social Security Number 6. Se	7. Age (In yrs. last bir	Months Days Hour	der 24 Hrs. 8. Date of Birth (Month, Day, Yea	N/A 9. Birth	hplace (State or Foreign
70	irector		Usual Residence of Decedent	46	Yrs.	1 Oct. 8,19	63 MG	cryland
e Marylar	a-f show	ctor	10a. State 10b. County	N/A 10c. City, Town	3 3 3 3	•		10d. Inside City Limits
th with th	23a or 20 ust be no	Funeral Director	340 E Bal	truice St. A.	10f. Zip Code 2/2	10g. C	Citizen of What Cou	untry?
d 21215-0036 filed within 72 hours after death with the Maryland Hygiene.	Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinatmust be notified at once.	þ	11. Marital Status 1 Never Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1	13. Was Decedent of Hispanic If Yes, specify Cuban, Mexi 1 □Yes 2 No Spec		14. Race - Amer Black, White Specify:	
21215-0036 d within 72 hours aff	er than "natu the Medical	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)		Decedent's Usual Occupation (Give kind of work done during m life, DO NOT use retired)	nost of working	Self	pologed
Maryland od 2 should be file Ith and Mental Hy	rked oth	To Be (17. Father's Name (First, Middle, Last)	8	unk. Ca	other's Name (First, Middle, Maide	n Surname)	
and 2 short ealth and ?	er trauma		19a Informant's Name/Relationship (7)	rpe. Print) . 19b WIFE 34	Mailing Address (Street and Nur	mber or Rural Route Number, City	or Town, State, Z	ip Code) Not 5
Baltimore, permit. Pages 1 ar Department of Hea	tant: If item Jury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify,	Removal from State cemeter	Disposition (Name of y, crematory or other place).		Location - City or T	
Balti permit. Departr	any in once.		21. Signature of Funeral Service Luce of	ee	22. Name and Address of Fa	cility 270 fred H	LTON PE	21229
	sician		23a. Part 1 E for the disease, or complished in heart failure. List only of immediate cause (Final disease or condition	ications that caused the death. Do not be cause on each line.	ot enter the mode of dying, such	as cardiac or respiratory arrest,		Approximate Interval Between Onset and Death
	edical miner	_	resulting in death) Sequentially list conditions,	Due to (or as a consequence of	1/15/45			24 hars
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	certi	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	lospital:	Other	ace of Death (Check only one)		
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Division of I or Attending Phy after death.	al Director: A ed in by the fu	Certification: To	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, far building, etc. (Specify)		28f. Location (Street a City or Town, Sta	and Number or Rui te)	ral Route Number,
To the Hospital or A within 24 hours after	e Funeral	Medical C	29a. Certifier (Check only one) 1 Certifying Phy 2 Medical Exami	sician: To the best of my knowledge ner: On the basis of examination and and manner stated.	death occurred at the time, date d/or investigation, in my opinion, o	and place, and due to the cause death occurred at the time, date a	(s) and manner as nd place, and due	stated. to the cause(s)
To th within	To th comp	Me	29b. Signature and title of of rtifier	0	29c. License numbe		Pate signed (Month	
			30. Name and address of person who co	File II in Reli	MO 2:22	7/		
F	Stat Registra	•	31. Date filed (Month, Day, Year) 5 2	32. Registrar's Signature	bares	1		

State of Maryland / Department of Health and Mental Hydiene

		1 - State Registrar	ato of Mary		Certificate of L			2010	00622
Disc.		Decedent's Name (First, Middle, Last)			-		Date of Death Month	Day Year	3. Time of Death
Physic /Med		LOIS HILLMON						11, 2010	1:00 P M
Exam	iner	4a. Facility Name (If not institution, give street	and number)			Location of Death		4c. County of Dear	th
.		712 VINE STREET 5. Social Security Number 6. Sex	7. Age (In	yrs. last birtho	BALTIMO	ORE If Under 24 Hrs.	8. Date of Birth	9 Birt	tholace (State or Foreign
Funera Directo		265-80-3054 Usual Residence of Decedent		Yrs	Months Days	Hours Min.	8. Date of Birth (Month, Day,) MAY 4,	(ear) Co	thplace (State or Foreign ountry) VA
yland Iow		10a. State 10b. County	10c.	. City, Town o	r Location		-		10d. Inside City Limits
Mary a-f sh	ctor	MD		BALTI	IMORE				1 X Yes 2 □ No
or 28	Jire	10e. Street and Number			10f. Zip Code		100	g. Citizen of What Co	ountry?
ath w	rall	712 VINE STREET				201		USA	
if e). Malf y Idinia Z IZ 15-0050 s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Exercities must be notified at	by Funeral Director	1 Never Married 2 Married 1	/as Decedent Ever i rmed Forces? ∐Yes 2 X No Yes, Give	n U.S.	13. Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 ▼No	ispanic Origin? (Spe n, Mexican, Puerto F Specity:	cify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify:	
hours aff	ed b	3 Widowed 4 Divorced Ÿ 15. Decedent's Education	ear or Dates:	16a D	ecedent's Usual Occup	ation	16	6b. Kind of Business/	BLACK
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rice file tal Hy dothe	Be (17. Father's Name (First, Middle, Last)				18. Mother's Name	(First, Middle, Ma	niden Surname)	
arylary should be ind Mental s marked o	P	SOLOMON HARRISON		-		QUEEN	JORDAN		
Vicinity of the model of the mo	1	19a. Informant's Name/Relationship (Type. P	rint)	19b. M	failing Address (Street a	and Number or Rura	l Route Number, (City or Town, State, 2	Zip Code)
thealth		MYRA HILLMON-MACON/D 20a. Method of Disposition			12 VINE ST	REET BA	LTIMORE,	MD 2120	
Dallillore, permit. Pages 1 an Department of Heal Important: If item 2 any injury or other		1 ☑ Burial 2 ☐ Cremation 3 ☑ Remov	al from State	cemetery,	crematory or other place	e) !		•	
nit. Parantme artme brtani injuny	i i	4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee	<u> </u>	LEASAN	22. Name and Address			DREWRYVILI	NS F.H., INC.
Dan permi Depar Impor any ir	Š.	James 9. 7	nate	37	1701-31 L			LTIMORE, N	
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/Medical	-	resulting in death)	Due to (or as a con	sequence of):	:				
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To the Hospital or Attending Physician: The law requires that the death ce within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attendit completely filled in by the funeral director, page 2 should be detached for use	Physician/	23b. Was decedent pregnant in the past 12 months?	yes, outcome of pre ☐ Live birth 2☐F ☐ Pregnant at time ☐ Unknown	etal death	3 Ectopic pregnancy 5 Other (specify)	′		23d. Date of de Month	livery Day Year
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ttenc death ctor: y the	icat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	e. Place of Injury - A	t home farm		/es 2 □No	98f Location (Stre	et and Number or Ri	ural Route Number
ital or / irs after ral Dire	Certification:				, street, factory, office		City or Town,	State)	
he Hosp in 24 hou he Fune pletely fil	Medical	29a. Certifier 1 Certifying Physician (Check only one) 1 Medical Examiner: (a	n: To the best of my On the basis of exam nd manner stated.	knowledge, d nination and/o	leath occurred at the tin	ne, date and place, a pinion, death occurre	and due to the cau ed at the time, date	use(s) and manner as e and place, and due	s stated. s to the cause(s)
Vith Voith Com	Σ	29b. Signature and title of certifier	,	. ~	29c. License	number		I. Date signed (Mont	
		Mest adams	note .	M.D.	(780)	887307		January 1	14,2010
2		30. Name and address of person who completed the Adam	Guts 4.//	Item 23a) (Typ	pe, Print)	S. B.11	11	717	01
St	tate	31. Date filed (Month, Day, Year)	32. Registratis Si	gnature	5. Greene	-1. Vair	mare mil	0, 0	
Regist	trar	JAN 1 5 201	n M	. 6	hould				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 13, 2010 2:32, PM Physician TANUARY Mary Eulalia Harbaugh /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a Faqility Name (If not institution, give street and number) Examiner If Under 1 Year | If Under 24 Hrs. | 8 N/A Birthplace (State or Foreign Country) Date of Birth 6 Sex (In vrs. last birthday) Funeral Months Davs Hours 1 □ M 2 F 07/07/1926 Maryland 192-26-1892 83 Director Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10b. County ed other than "natural", or items 23a or 28a-f show event, the Medical Evaluation and the motified at 1 ☐ Yes 2 XNo Director MD Baltimore Catonsville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 719 Maiden Choice Lane 21228 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11 Marital Status 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: White If Yes, Give Year or Dates: <u></u> 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 th and Mental Hygiene. 7 Is marked other than "r College (1-4or 5+) Elementary/Secondary (0-12) Medical Medical Technician 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary O'Rourke John P. Harbaugh injury or other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2
Department of Health a
Important: If item 27 Is, Pat Miller (Nephew/POA) 329 Prospect Bay Drive, Graysonville, MD 21638 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State St. Patricks Cemetery 1/18/2010 Cumberland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lidensee 22. Name and Address of Facility Hubbard Funeral Home, 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. INFAR CTTO Immediate Cause (Final MYOCARDIAL 1 HOUR **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last To the Hospital or Attending Physician; The law requires that the death certificate be exect Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760; attending physician for use as the buria Physician/Medical If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
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To the Fune

completely f

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CURTIS egistrar's Signature

DU051865 JANMRY 13,240 HUSPITHE BACTIMORE, MIS CMOUN AVE 21229

10-00159	
Virginia Holter	

viigi	nia Hoiter		1- For State Registrar	Sta	te of Maryla		epartment Certificate			Menta	l Hygiene	Reg. No	. 201	0 00624
Med	Physici lical Exami		1. Decedent's Nam	le (First, Middle,		HOLTI	ER				2. Date of D Month January	Day	y Year 10	3. Time of Death 0926 hrs
			4a. Facility Name (Johns Hopl		give street and nu Medical Cen				ty, Town, or L Iltimore	ocation of [eath	1	4c. County of De	
	Funeral Director		5. Social Security N		5. Sex 1 M 2 X F		rs. last birthday)		Under 1 Year onths Days	If Under 2 Hours	4Hrs. 8. Date of Min. 05/2	·	Fo	Birthplace (State or reign Country) MD
ĺ	any		Usual Residence o	f Decedent 10b. County		10c. (City, Town or Lo	cation						10d. Inside City Limits
)	* .	×	MD	-	I/A		BAL'		ORE					1 X Yes 2 No
-	th the Maryland 23a or 28a-f show notified at once.	Director	10e. Street and Nu					10f.	Zip Code	<u> </u>		10g. C	itizen of What C	ŕ
	vith the s 23a or		2035 FA	IRMOUN	12. Was Dec		nUS 13	Was Dec	212		(Specify Yes or	No-	U.S.	, A .
	MD 21215-0036 d.2 should be filed within 72 hours after death with the Maryland Ill and Mensal Hygiene in Ill and Mensal Hygiene no no in a name i	by Funeral	1 X Never Marri		Annual C	orces?	0	If Yes, sp		Mexican, Po	uerto Rican, etc.)		White, etc	
	136 hin 72 hours afte e. than "natural", edical Examiner	ted b	15. Decedent's Ed		y only highest grad				ual Occupatio working life. [d of work done e retired)	16b.	Kind of Busine	ss/Industry
	nore, MD 21215-0036 ggs 1 and 2 should be filed within 72 hours after nn of Health and Mental Hygiens. I. If titem 27 is marked other than "natural", other traumatic event, the Medical Examiner	Completed	Elementary/Seco	ondary (U-12)	College (1	-4 or 5+)]	DISA	ABLED				N/A	A
	e, MD 21215-003(1 and 2 should be filed within Health and Mental Hygiene. item 27 is marked other that r traumatic event, the Medit	ø	17. Father's Name						18		lame (First, Middle		en Surname)	
	212 ould be d Ments s mark tic even	To B	GEORGE 19a. Informant's Na		HOLTER p (Type, Print)		19b. Mai	ling Add	ress (Street a	JUD and Numbe	Y WOO r or Rural Route N		City or Town, St	ate, Zip Code)
	ore, MC is 1 and 2 st of Health an If item 27 i		GEORGE 20a. Method of Dis		R/ FATHE		532				AD, BALT		DRE, MD	21237
	nore		1 Burial 2	X Cremation	3 Removal fro	om State	crematory or BAYVIE	other pl	ace)				•	ORE, MARYLAN
	Baltimore, MI permit. Pages I and 2 s Department of Health a Important: If item 27 injury or other traum		21. Signatur	Other Spenneral Service Li			21 22	L I L I	and Address o	EILE	R INC.	FUN	JERAL H	IOME
	ய கூற்து.த Physician		23a. Part I. Enter th	ne disease, or co	omplications that ca	aused the de	1	1901	EAST	ERN	AVENUE,	BAL	JTO., ME	21231 Approximate Interval
	Examiner		failure. List on Immediate Cause (or condition resulting		n each line. a. <u>Myocard</u> Due to (or as a			on						Between Onset and Death
		iner	Sequentially list co if any, leading to in cause. Enter Under	nmediate	b Due to (or as a	consequenc	ce of):							
	cuted nd ransit	ledical Examiner	(Dissass or injury t events resulting in	nat initiated	Due to (or as a	consequenc	e of):							
	50, te be executed ysician and burial - transit	edica	X UNPENDED		AMENDED 3	a,PII	,27,perm	nE g	399 1/2	20/10	TT			
	c 6876 certifical ending ph use as the	-≥1	IF FEMALE: 23b. Was decedent past 12 months	97	23c. If yes, of the Live b	outcome of p irth ant at time of	regnancy 2	Fetal dea	ath 3	Ectopic pr		2	3d. Date of deliving Month	very Day Year
	• 4 >4		Part II. Other signi				ot resulting in th	e underl	ring cause giv	en in Part I	23e. Did	d tobacco	o use contribute	to the cause of death?
	S, P.	ed by	H:	istory o	of narcot	ic use	2							robably 4 Unknown
	Division of Vital Records, P.O. Boy and or Attending Physician: The law requires that the death stard cash as there death stard cash. After this certificate has been signed by the attein by the funeral director, page 2 should be detached for	Completed									per	as an topsy rformed? s 2	prior death	autopsy findings available to completion of cause of ? Yes 2 No
	/ital sician: is certif lirector,	a	25. Was case reference examiner?		Hospital 1	npatient 2	✓ ER/Outpatie	ent 3		thor:	eck only one) ursing Home 5	Resid	dence 6 Ot	her:
	on of Vil ending Physicath ath or: After this he funeral dir	tion: To	27. Manner of Deat 1 X Natural	5 Pendin	,28a. Date (Month,		28b. Time o		28c. Injury		28d. Describ		njury occurred	
	Division of No the Hospital or Attending Ph. within 24 hours after death To the Funeral Director: After tl completely filled in by the funeral	Certification:	2 Accident 3 Suicide 4 Homicide	6 Could r	not be 28e. Place	e of Injury - A	at home, farm, st	treet, fact	ory, office buil	lding, etc.	28f. Location or Town		and Number or	Rural Route Number, City
	Fo the Hosp within 24 ho Fo the Fun completely I	Medical C	29a. Certifier (Check only one) 2		sician: To the bes iner:On the basis of and manner st	of examinatio	-							
	. , , = 0	Σ	29b Signature and	John.	Veek	1 400	50		29c. License r O.C.M.				Date signed (innuary 7, 201	Month, Day, Year)
d			30. Name and address of person who completed cause of death (Item 23a) Victor Weedn MD JD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201											
	St	ate	31. Date filed (Mont	H. Day Year)	2010 32. Re	gistrar's Sign	nature /	bark	lan!					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 19b, per Fh g899 1/15/10 TT

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 11:10 P M 13, 2010 January April Lynn Holland /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Harford Upper Chesapeake Medical Center Bel Air Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 M 2 3/F Oct. 14, 1984 Virginia 228-51-2537 Director 25 Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10b. County 10a. State ral", or items 23a or 28a-f show 1 ☐ Yes 2 No Director Bel Air Maryland Harford 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2304 Shoreham Court Apt. C 21015 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Specify: White þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Accounting permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hyglen Important: If item 27 Is marked other the any Injury or other traumatic event, Ilm. 9008. Bookkeeper 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Connie Lee Russell Scottie Lynn Holland ည 19b. Mailing Address (Street and Number or Rural Boute Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 16823 Polish Town Rd. Williamsburg, VA 23089 Connie Holland/Mother 20b. Place of Disposition (Name of cemetery crematory or other place)
Evans Funeral Chapel 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Jan. 15, Forest Hill, Maryland 2010 Bel Air 2010 Forest HIII, Fully Law 22. Name and Address of Facility Evans Funeral Chapel & Cremation Service—BelAir 21. Signature of Funeral Service Licensee 3 Newport Drive Forest Hill, Maryland 21050 23a. Part 1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arresponds, or heart failure. List only one fault on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cancer Metastatic eme 4 month Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to infine diate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dualto (or as a nonsequence of) Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 morths? Month Dav Year 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 1 Nes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 □Yes 2 🗹 No Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certifica 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check o and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier January 14th 2010 D 45390 30, Name and address of person who completed cause of death (Item 23a) (Type, Print)

Myo (Nin (M,D) COZ Sowth Atwood Road # 200, Bel Air; 31. Date filed (Month, Day, Year) State Registrar

M800514

			For State	State of Maryla		epartmei Certifica			and Me	ntal Hy	gien	e 2 0	10	00626
		_	Registrar 1. Decedent's Name (First, Middle, La.	st)		Certifica	te of L	Jeath	2	. Date of De	Reg. No	o	1 0	3. Time of Death
	Physici		Otis Hill							Month Sanuar	D.		Year	1000 a M
	/Medid Examir		4a. Facility Name (If not institution, giv			4b. City	, Town, or	Location of	of Death	JUL 10 0(1	7 40	c. County o		
				neral Hosp	Ital	100000	1/1/		Mi	>		N/A		
	Funeral		5. Social Security Number 6. S	GM 20 E		Yrs. If Under	r 1 Year Days	If Under Hours	Min. 1	Date of Bir (Month, Da 0 / 0 8	th ay Year 11 Q	61	Coun	lace (State or Foreign try) C1 da
	Director		212-72-7723 Usual Residence of Decedent		48				<u> </u>	0/00	, 10	01	E 101	. i da
	ryland Show	_	10a. State 10b. County	10c. 0	City, Town	or Location							10	Od. Inside City Limits
	Ba-f s	Director	MD	N/A		Baltin								1 Yes 2 No
n	a or 2	Dir	10e. Street and Number			10f. Zi	ip Code	4047		:		itizen of Wi	nat Coun	try?
H	death	Funeral	1836 Clifton A	12. Was Decedent Ever in	U.S.	13. Was Dece	edent of His	1 2 1 7 spanic Ori	igin? (Speci	fy Yes or No		S.A.		
1 0	after death with the Maryland or items 23a or 28a-f show	Ē	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give			·	n, Mexicar Specify:	n, Puerto Ri	can, etc.)			White, e	etc.
-003	ural",	d by	3 Widowed 4 Divorced	Year or Dates:	- 10	1 □Yes						Specify:		ack
15	in 72 l	olete	15. Decedent's Ec (Specify only highest gra	ade completed)	16a.	Give kind of we life. DO NOT u	ork done d	uring mos	t of working		16b. I	Kind of Bus	iness/inc	iustry
212	d with giene ar thau	Completed	12th Grade	College (1-4or 5+)	As	sembly	y Lir	ne C	ontro	oller	Di	etz&	Wat	tson
20	oe file tal Hy d othe event	Be (17. Father's Name (First, Middle, Last)					18. Mothe	er's Name (i	First, Middle)	
ا ا	d Men darke	2	Loucious		11ma				ois			ison		
ムレバット Maryland 21	d 2 sh Ith and 27 is n traun		19a. Informant's Name/Relationship (Roxann Richard	(Wife)	n 196.	Mailing Addres	s (Street a	nd Numbe	er or Rural I	Route Numb	er, City M	or Town, S	tate, Zip つ17	Code)
	s 1 an if Hea item 2 other		20a. Method of Disposition	20b	. Place of	Disposition (Na	ame of	i	Dat	e e	20c. l	Location - C	ity or To	wn, State
HIBaltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Eventiner roughled at once.		1 ☐ Burial 2 【②Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif	Removal from State J	oser nd (n Brow Erematory or Brow	vn F7	/H ;	01/14	1/10	Ва	ltim	ore	, MD
Salt	permit. Departr Importa any Inju		21. Signature of Funeral Service Licer		1 -	22. Name a	and Addres	s of Facilit	own .	Ir. F	une	ral	Home	e
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			23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final	one cause on each line.	ath. Dor	Λ		g, sucn as	cardiac or i	respiratory a	irrest,			Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. He putic	und equence o	HNOX	IC Z	nce	Pha/0	path	/-	-		
The state of the s	Examiner		Commentation link and distance	End Sto	rae	1 ?ve	1	Si	sea:	S e	,			
SU	ed sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conse	e ence	p): (7	1:00	1	rest	para.			
h.	execut and al-tran	Examiner	that initiated events resulting in death) Last	c. Pratus Due to (or as a conse	equence o	- 1	ury	7,40	MTri	207				
8760	icate be executed physician and the burial-transit	dical E		_ d.										
Θ		Medi	IF FEMALE:		<u></u>									
Вох	leath certifi attending for use as	ian/I	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of preg	etal death							23d. Date Mon		ery Day Year
Ö.	at the de by the a tached f	Physician/Me	1 □Yes 2 □No 9 □ Unknown	4 ☐ Pregnant at time o 9 ☐ Unknown	of death	5 Other (s	specify)							
σ.	Phystcian: The law requires that the death certif this certificate has been signed by the attending ral director, page 2 should be detached for use as	by Ph	Part II. Other significant conditions	contributing to death but not re	esulting in	the underlying	cause give	n in Part I		23e. Did t	tobacco	use contril	oute to th	ne cause of death?
rds	w requires s been sig should bo									10	Yes 2	2 □ No 3	Prob	ably 4 Unknown
ecc	e law ru has be	Completed								24a. Was	psy	24b. W	ere auto	psy findings available npletion of cause of
<u>=</u>	: The icate h									perfo 1 ☐ Yes	2 🖳		ath? □Yes	2 □ No
Vit	slcian: The certificate irector, pagi	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:			Othe	r.		Check only o				
of	ding Phys h. After this funeral dii	<u>ان</u>	27. Manner of Death	1 Impatient 2	28b. T	ime of	28c. Injury	4 ⊔ Nu		d. Describe				γ)
ion	ath. pr: Aft	atio	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation		ır	njury M	Work' 1 □ Y	? /es 2 🗆	No					
Division of Vital Records,	or Attending after death. Director: After d in by the funer	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At building, etc. (Spec	home, far	m, street, factor	ry, office		28	f. Location (City or To			r or Rura	l Route Number,
	pital ours a leral C	8 -	29a. Certifier 1 Certifying Ph	ysician: To the best of my k	nowledge	death occurre	d at the tim	ne date ar	nd place an	nd due to the	cause	(s) and mar	ner as s	tated
ix	To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	ledical	(Check only 2 ☐ Medical Examone)	niner: On the basis of exami and manner stated.	ination an	d/or investigatio	n, in my op	oinion, dea	ath occurred	at the time,	date a	nd place, ar	nd due to	the cause(s)
~ (To th To th comp		29b. Signature and title of certifier	and language	21/	25	c. License	number			29d. D	ate signed	(Month,	Day, Year)
			Honelan	MILECOIN	JV	"	DI	23	> 0 3	· .	19	nugi) /	2010
			29b. Signature and title of certifier 20. Name and address of person who 31. Date filed (Month, Day, Year)	completed cause of death (It	em 23a) (Type, Print)	45	T. E	BAL	Ton	nD	21	21-	+
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Sign	nature									
	Registr	ar	JAN 1 4 2010	Cenara S.	Sa	at I								

			Please Type or P AMEND I State of State of Parietre	rint in Blac	k Indelible In	k. Ensure /	All Copies	Are Legible.	
		1	- State Registrar Amend 20b, per FH g8	99" 1'725/1t	Certificate of	Death	Re	g. No 2010	00627
•	Physicia Medic	n/	1. Decedent's Name (First, Middle, Last) HEARL		HARR	IS	2. Date of Death Month	Day 11 2016	
*	Examin	er		Circle #2	203 Wind			4c. County of Death Balfir	none
H	Funeral Director		5. Social Security Number 6. Sex. 1 AM 2 🗆 F	Age (In yrs. last birth	day) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 7	937 g. Birtl	nplace (State or Foreign ntry)
	rryland a-f show ied at	Director	Usual Residence of Decedent 10a. State 10b. County Bathmore	10c. City, Town	or Location dallstown	\cap	•		10d. Inside City Limits 1 ☐ Yes 2 🔀 No
	ith the Ma 23a or 28a st be notii	ral Dire	10e. Street and Number 9223 AllensWood Roa		10f. Zip Code	1133	10	Og. Citizen of What Cou	untry?
980	e filed within 72 hours after death with the Maryland that lyyglene. ad other than "natural", or items 23a or 28a-f show other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at.	ed by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decede Armed Force 1 Yes 2 If Yes, Give Year or Dates	nt Ever in U.S. s? No	13. Was Decedent of I	Hispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: 'Bl	
21215-0036	72 hours n "natur /edical	Completed	15. Decedent's Education (Specify only highest grade completed)	16a.	Decedent's Usual Occu (Give kind of work done life. DO NOT use retired	during most of work	sing 1	6b. Kind of Business I	
	ed within Hygiene. other tha	100	Elementary/Seconday (0-12) College (1-4)	or 5+) Bo		r Mecha		Automo	tive
Maryland	ould be filed of Mental Hygmarked oth	To B	17. Father's Named (First, Middle, Last) Cedrick Harris, Sr.				ne (First, Middle, Ma 10 Blac		
	2 shou th and th is m traum		19a. Informant's Name/Relationship (Tyge, Print) Teanie Wright/Daught	er 9:		swood f	al Route Number, Coad Ra	City or Town, State, Zip	Code) NMP 21/33
Baltimore,	Page 1 and inent of Healt ant: If item 2 ant: If or other any or other		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from St 4 ☐ Donation 5 ☐ Other (Specify)	ate cemeter)	Disposition (Name of the count crematory or other place)	ice)		Baltims	_
Baltir	permit. Pag Department Important: any injury once.		21. Signature of Funeral Service Licensee		22. Name and Addr	ess of Facility V	ughn (dillston	Tuneray suco IMD 21133
I			23a. Part 1. Enter the disease, or complications that caushock, or heart failure. List only one cause on each	sed the death. Do no line.	ot enter the mode of dyi				Approximate Interval Between Onset and Death
	hysician/ Medical		Immediate Cause (Final disease or condition resulting in death) a. Due to (or	as a consequence o	MILLUX	E			Offset and Death
	Examiner	ner	Sequentially list conditions, if any, leading to immediate b. Due to (or	as a consequence o	ENSIT	<u> </u>	1-111	=,00	
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09,	ate be ex ohysician the buria	- 1	L _{d.} <u>A</u>	1040L A	ABUSE		<u> </u>		
Box 68760	Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death. Funeral Director: After this certificate has been signed by the attending physici atted filled in by the funeral director, page 2 should be detached for use as the buse.	Physician/Medica		th 2 Fetal death nt at time of death	3 ☐ Ectopic pregnar 5 ☐ Other (specify)	ncy		23d. Date of del Month	ivery Day Year
, P.O.	ires that the dea signed by the a Id be detached f		Part II. Other significant conditions contributing to dea	th but not resulting in	n the underlying cause o	given in Part I.		acco use contribute to	the cause of death?
Vital Records,	law require nas been si e 2 should l	Completed by					24a. Was an autopsy perform	y prior to o	copsy findings available completion of cause of
al Re	ding Physician: The law th. After this certificate has funeral director, page 2	Be Cor	25. Was case referred to medical examiner?		26. 1	Place of Death <i>(Che</i>	1 🗆 Yes 2		2 🗆 No
of Vit	Physic rr this ce eral direc	은	1 ☐ Yes 2 No 1 ☐ In 27. Manner of Death 28a. Date of		ime of 28c, Inju	ury at	ome 5 Resider	nce 6 Other (Spec	THE S
Division of	ttending death. tor: Afte the fun	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be		njury wo M 1 E	Yes 2 No	29f Location /Str	eet and Number or Rui	ral Route Number
Divis	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completed filled in by the fun		4 - Homiciae determined building	, etc. (Specify)			City or Town,	State)	
$\overline{\mathbf{S}}$	he Hosp in 24 hou he Fune ipleted fi	Medical	29a. Certifier 1 Certifying Physician: To the best (Check 2 Medical Examiner: On the basis only one) 3 Certifying Nurse Practioner: To	of examination and/or	r investigation, in my opir	nion, death occurred	at the time, date and	d place, and due to the	cause(s) and manner stated.
<i>y</i>	To t with To t		29b. Signature and title of certifier	e mi	29c. Licen	2545	9 29	9d. Date signed (Month	n, Day, Year) 2010
	2.1		30. Name and address of person who completed cause	of death (Item 23a) (Type, Print) HTL	NET RI BUSINI	E N)	CROSSRED 2122	ALS #100
	Sta Registr		31. Date filed (Month, Day, Year) JAN 1 4 2010 32. Reg	istrar's Signature	Med	411			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 00628 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Dav Year :42 rrison PM Medical 2010 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City or Location of Death 4c. County of Death tsalti More ge (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Min **Director** Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location with the Maryland the Medical Examiner must be notified at 10d. Inside City Limits Director Bultimore 1 Yes 2 No 10e. Street and Number ò 10g. Citizen of What Country? Funeral USA "natural", or items 23a filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, 1 ☐ Yes 2 No If Yes, Give Year or Dates. Black, White, etc. 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Divorced 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DQ NOT use retired) th and Mental Hygiene.
It is marked other than traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) laintenance Be Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ျှ permit. Page 1 and 2 should be Department of Health and Ments Important: If item 27 is marked nformant's Name/Relationship (Type, Print) or Rural Route Number, City or Town, State, Zip Code) Hallimore other 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other injury or 4 Donation 5 Other (Specify) of Fune al Service 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ Due to (or as a consequence of) disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events as a consequence of Exam To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit and Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year Pregnant at time of death signed by the a 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 No certificate has 1 Yes 2 No 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital 2 No Other: မ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this Date of injury (Month, Day, Year) 27. Manner of Death Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural injury Accident 5 Pending within 24 hours after death.

To the Funeral Director; A: Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Lecritifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioners. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) Signature and title of certifie 29c. License number 29d. Date signed (Month. Dav. Year) 12, 2010

State Registrar drion

ess of person who completed cause of death (Item 23a) (Type, Print) MID

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Lost) 2. Date of Death 3. Time of Death Month Day Vear Physician 09:48 PM amue seorae JANUARY 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner AGNES BALTIMORE If Under 1 Year | If Under 24 Hrs. | 8, Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours Nov. 28 215-05-625 1 M 2□ F Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County in is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modeal Evaminar must be notified at 10a, State 1 ☐ Yes 2 🐪 **Funeral Director** atonsville timore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21228 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 17XYes 2 ☐ VYes, Give Year or Dates: 1 ☐ Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: δ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. If O NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Department of Health and Mental Hygiene important: If item 27 is marked other than ' any injury or other traumatic event, the Me ones, and ones. (Secondary (0-12) College (1-4or 5+) bore Father's Name (First, Middle, Last) Be Health and Mental 19b. Mailing Address (Street and Number or Rural Route Number, City or Baltimore, 20a. Method of Disposition Pages 1 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) av re of Funeral Service Lice 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MENTUN **Physician** Myposlycama /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter or certifications of Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): law requires that the death certificate be executed burial-tran Due to (or as a consequence of): 68760 Physician/Medical Box IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No Ö 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 No 3 Probably 4 Ponknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy rmed 2 No 1 ☐ Yes Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To ō 28a. Date of Injury (Month, Day, Year) 27. Manper of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Division **Hospital or Attending** 1 Matural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu 2 Accident 6 □ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 11 address of person who completed cause of death (Item 23a) (Type, Print) 30. Name an Box 134 Bathmore, 900 Couton News 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Year Month 12.52PM **Physician** HICKS OI 10 A DA 6 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Towson Manor Care - Dulaney 8. Date of Birth (Month, Day, Year)
Dec. 11, 1915 Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Days Hours **Funeral** 94 1 M 2 J Yrs. 220-48-7094 Director Usual Residence of Decedent 10d. Inside City Limits permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event. the Medical Examination 10c. City, Town or Location 10b. County 10a State 1 ☐Yes 2 No Chase Baltimore MD Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21027 13023 Eastern Avenue Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. White 1 Never Married 2 Married Specify: 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 Completed by 3 XWidowed 4 ☐ Divorced 16h. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) own home Homemaker 8th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be unknown Harry Kesler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Raltimore MD 21 027 19a. Informant's Name/Relationship (Type. Print) 13023 Eastern Avenue Baltimore MD Wesley J. Hicks Jr. /son 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of place Holly Hill Cemetery 1/11/10 Baltimore MD 22. Name and Address of Facility 300 Mace Ave. Balto. MD 21. Signatory Funeral Service Lice 1 Connelly Funeral Home of Essex 21221 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Arrythmia Physician disease or condition resulting in death) Due to (or as a consequence of): /Medical Stenon Examiner Anni Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Dement requires that the death certificate be executed bunial-tra Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical use as the IF FEMALE 23d. Date of delivery 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal dea
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 3 Ectopic pregnancy Day Year 2 Fetal death Month in the past 12 months? 1 ☐ Yes 2 ☑ No 5 ☐ Other (specify) cate has been signed by the page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Únknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1□ Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? funeral director, Be Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) s after death 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide determined filled in by 4 ☐ Homicide ŏ 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 24 hours 29a. Certifier Medical within 24 hou

To the Fune

completely fi 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D31464 MD

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

N. EUTAW ST SNITE 305

BACTIMORE MD 21201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ITASITONI MD

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 01-06-2010 **Physician** 0550 P M Marie Estelle Herbert /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Towson Baltimore Holly Hill Nursing & Rehab. Center | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 0 | Months | Days Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 ☑ F 90 217-01-6369 MD Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show 1 □ Yes 27 No ? is marked other than "natural", or items 23a or 28a-f sh traumatic event, Its Medical Evanimer hust be molffied Director Glen Arm MD Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21057 USA 12512 Long Green Pike Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☒No IfYes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify Specify: White ģ 3 ☑ Widowed 4 ☐ Divorced n and Mental Hygiene. Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Housewife 10 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Marie Stallman William Lutz 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health ar Important; If item 27 is any injury or other trau once. MD 21057 11748 Harford Rd Glen Arm Jeannette Kempske (daughter) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burlal 2 M Cremation 3 ☐ Removal from State 01-08-2010 Baltimroe, MD 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home of BelAir Inc 610 W. MacPhail Rd Bel Air, MD 21014 Approximate Interval Between Onset and Death 23a. Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** 20 years disease or condition resulting in death) 01000 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter University Cause (Disease or injury Examiner Due to (or as a consequence of) signed by the attending physician and d be detached for use as the burial-trar resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown icate has been si ; page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed certificate 1 ☐ Yes 2 ☐ No División of Vital within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 27. Manner of Death 1 Natural Certification: 28a. Date of Injury (Month, Day, 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Hospital Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 402 touk Year) 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death **Physician** Veda Μ. Month Hartman January 5, 2010 07:20pm /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examine North Hampton Manor Frederick Frederick If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 106-14-2330 Months Days Hours 1 □ M 2√2 F 93 Director March 31,1916 PA Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the fredical Examiner must be notified at NY Erie West Seneca Director 1 ☐ Yes 2XXXNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 158 Chamberlin Drive 14210 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 XXXo Specify: white þ ₩Widowed 4 Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 12 should be filed with and Mental Hygier 7 Is marked other the Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 Is marked of any injury or other traumatic ev George Mullen Nancy Stuller ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 101 Maple Drive, Orchard Park NY 14127 Edward Hartmen / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Saint Matthews Cemetery 1/25/10 West Seneca, NY 4 Donation 5 Other (Specify) Ture of Floring Service License Victor P. Doda, Jr²² Name and Address of Facility
Charles L. Stevens Funeral Home, Inc.
1501 East Fort Avenue, Baltimore MD 21230 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** zhaimer disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of) physician a s the burial-1 Box 68760, Physician/Medical as attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) P.0. 1 ☐ Yes 2 ☐ No been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24a. Was ar 24b. Were autopsy findings available prior to completion of cause of s certificate has b irector, page 2 sl autopsy performed? Yes 22 No The death? 1 ☐ Yes 2 ☐ No 1 ☐ Yes Division of Vital Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this After th funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred or Attending 5 ☐ Pending investigation Natural death. 2 Accident 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 3/05

State Registrar 31. Date filed

10200 Coppermine

32. Registrar's Signature

Woodsboro mo 21798

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Month, Day, Year, 1 4 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** -LIZABETH PATRICIA HARRIS-GOLDSTEIN 1:30 AM JAN 13 2010 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner OAKLAND MILLS 12040 SYKESVILLE CARROLL 6/04 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 ☐ M 2 🕱 F Months Days Hours 215 30 4203 Director FEB 26 1930 MARYLAND Usual Residence of Decedent 10a. State 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MW CARROLL SYKESVILLE 10e. Street and Number 10g. Citizen of What Country? 6104 21784 USA OAKLAND MILLS Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or Items 23: 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black White etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: WHITE 1 ☐ Yes 2 No þ 3 ☐ Widowed 4 ☑ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry CHURCH HOME Elementary/Secondary (0-12) College (1-4or 5+) SECRETARY 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) JAMES PETIT HARRIS ENNA MACARITHY WINTERSON 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) OAKLAND MILLS ROAU SYKESVILLE, MO 21784 JEONGE SON 6104 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of Important: If it any Injury or o 1 ☐ Burial 2 Cremation 3 ☐ Removal from State CARROLL CREM /-14-2010 WINFIELD, MID 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility JNZUMBRUN EH & MONCO. 21. Signature of Funeral Service Licensee SYKESVILLE RO ELDERS BURGMO 21784 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** terioscle rost 20 Years disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate caus. Enter the cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) 9□Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No performe 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 27 No Hospital: 1 | Inpatient | 2 | ER/Outpatient | 3 | DOA Other: ٩ 4 Nursing Home 5 MResidence 6 □Other (Specify) 27. Manner of Death Natural 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation within 24 hours after dearn.
To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0020964 January 14, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1100 Reisterstown Road Suite 202 Pikesville, MD 21208 Jerome H. Ginsberg, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 1. par Registrar

			For State Registrar	State of Ma	arylan		artment o <i>tificate o</i>				giene Reg. N	201	0 0	0634
	Physicia	n/	Decedent's Name (First, Middle, in the control of the control	Last)						2. Date of Dea	ath	ay Year		me of Death
	Medic	al	Howard Hor	sey, Jr.			4b. City Tour	orlo	cation of Death	Januar	y 1			8:00 p ^M
	Examin	er	Best Care						stown		1	•	imore	
	Funeral Director				e (In yrs. la	ast birthday) 3 Yrs.	If Under 1 Ye Months Da		Under 24 Hrs. lours Min.	8. Date of Birt (Month, Dat March	h (, <u>Y</u> ear)	1926 N	irthplace (S <i>Country)</i> 1ary1a	state or Foreign and
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nd	filed wall Hyginal Hyg	Be	17. Father's Name (First, Middle, Las	st)				_	l. Mother's Nam	e (First, Middle,	Maiden	Surname)		
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	1 and 2 should be if Health and Men item 27 is marke other traumatic		19a. Informant's Name/Relationship Michelle Delgado				g Address (Stre anklin			al Route Numbe isterst			Zip Code) 1136	
Baltimore,			20a. Method of Disposition 1 Burial 2 □ Cremation 3		20b. F	lace of Dispo	sition (Name of natory or other)			Date		ocation - City		ate
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Ba	permit. Departr Imports any inji		21. Signature of Funeral Service Lic	enseem - De	nk		. Name and Ad line Fu		1.1	824 Rei Reiste	ste: rst	rstown own, MD	Road 211	36
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	Physician/ Medical	8 3	disease or condition resulting in death)	a. Due to (or as a	a consequ		dem	ny	tia				1	
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sion	ttendi death. ctor: A y the fu	Certificate:	2 Accident Investiga 3 Suicide 6 Could no	ot be	ırv - At ho	me farm stre			2 □ No	28f. Location (S	Street or	nd Number or E	Pural Route	Number
Division of Vital Records,	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,		4 Homicide determin	building, etc	. (Specify)	ot, factory, offi			City or Tow			iurai rioute	
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			Steph	> waget 1	w		102	83	04		1//	13/201	0	
			30. Name and address of person what the phen	to completed cause of de	eath (Item	23a) (Type, P	ain St	Re	istersi	townN	in:	2113		
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			1 - For State Registrar	State of Ma	ırylan		artment rtificate			nd M	ental Hy	/gien	20	10	00635
	Physicia		1. Decedent's Name (First, Middle, Last BERTHA		RT						2. Date of Do Month	eath Da	ay	Year	3. Time of Death 7:02 AM
	/Medic Examin		4a. Facility Name (If not institution, give HARBOR HOSPIT						ocation of		SKANL	40	c. County of		
	Funeral Director		5. Social Security Number 6. Se 219–16–5850	х] M 2 Д F	(In yrs. 84	last birthday) Yrs.	If Under Months		If Under 24 Hours	4 Hrs. Min.	8. Date of Bi Month, D Nay 2	rth av, Year 9, 19	25	Count	ace (State or Foreign ry) ylvania
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	with the	al Direc	10e. Street and Number 43 East Henrietta St	reet			10f. Zip	Code 21230	0			10g. C	itizen of W		ry?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, The Medical Evaluation in ust he multiple at once.	Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 □ Yes 2 N If Yes, Give Year or Dates:			Was Deced fYes, spec l⊡Yes 2	ent of Hisp ify Cuban,		in? (Spe Puerto F	cify Yes or N Rican, etc.)	0-		- America , White, e	tc.
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A/	To ti withi To ti	Ž	29b. Signature and title of certifier R	sident				RES		0		29d. B	ate signed	(Month, I	Day, Year)
			30. Name and address of person who can be seen address.	4 AHME	D,	3001	Print) S H	ANDI	VER	Sti	reet,	Bar	tin	ore	-, MD
	Sta Registr		31. Date filed (Month, Day, Year)	2. Registra	r's Signa	ture	del .								

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	h the Maryland a or 28a-f sho be notified at	al Dire	10e. Street and Number	more	10f. Zip Code		10g.	. Citizen of What Co	1 🗆 Yes 2 No
9	72 hours after death with the Maryland "matural", or items 23a or 28a-f shc Aedical Examiner must be notified at	by Funeral Director	3 [#] Walden Ch 11. Marital Status 1 □ Never Married 2 □ Married	2. Was Dededent Ever in U.S. Armed Forces?		an, Mexican, Puerto P	cify Yes or No- lican, etc.)	14. Race - Ame Black, White	
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Mary	O + D =		19a. Informant's Name/Relationship (Type, Alex Jacobs Ja	Print) - Son 9	b. Mailing Address (Street	and Number or Rural	Route Number, City	y or Town, State, Zij	Code)
Baltimore,	of Hea of Hea fitem		20a. Method of Disposition 1 Seurial 2 Cremation 3 Re	emoval from State \(\int\) cemete	of Disposition (Name of ery, crematory er other place	ce) //s	ate 200	. Location - City or	Town, State
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of Vi	Physi rthis c rral dire	은	1 Yes 2 No Pros	1 Inpatient 2 ER/O	utpatient 3 DOA Time of 28c. Injur	4 ☐ Nursing Hor	ne 5 Residence	other (Spec	ity) NOSPIGE
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Division of Vital Records,	or Direction		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, fa building, etc. (Specify)	arm, street, factory, office	2	8f. Location (Street City or Town, St	and Number or Rui ate)	ral Route Number,
·×	e Hospital n 24 hours ie Funeral	Medical	(Check 2 Medical Examiner	an: To the best of my knowledge, on the basis of examination and/oractioner: To the best of my know	or investigation, in my opinion	on, death occurred at t	he time, date and pl	ace, and due to the	cause(s) and manner stated.
10	To the He within 24 To the Fu		29b. Signature and title of certifier	4.0	29c. Licens	e number	29d.	Date signed (Month	n, Day, Year) Y ZOIO
	3		30. Name and address of person who com	ipleted cause of death (Item 23a)	(Type, Print)	0707	<u> </u>		1 0010
			AMON J CHAR 31. Date filed (Month, Day, Year)	WS W) 6701	N Chale	J (T T	MISON	m)	
	Sta Registra		JAN 15	2010 Line	P. 18				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** MUARY 2010 /Medical 4c. County of Death Facility Name (If not institution, give street and number) Town, or Location of Death Examiner TANAPUL SISTED -10106 UNDEL If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Min. 1 □ M 2 1 F 010-22-9353 82 June 4,1927 MA Director Boston Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Widon Even in contact be notified an once. 10b. County 10a, State 1 ☐ Yes 2 ☑ No Director Anne Arundel Odenton MD 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 21113 U.S.A. 2404 Chestnut Terrace Court Apt. 301 Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: à 3∑ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Protocol Officer US Army 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Helen Urbanowicz John Lankiewicz 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 93 East Centre Avenue Newtown, PA 18940-1903 Ms Monica J. Morgan/Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition January 1 Burial 2 □ Cremation 3 □ Removal from State Arlington Nat. Cem. 26, 2010 Arlington VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Singleton Funeral & Cremation 21. Signature of Funeral Service License Services PA 1 2nd Ave. SW Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician DeNEI disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of): inding physician ause as the burial Box 68760, Physician/Medical IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregr 23d. Date of delivery atter 3 🗆 Ectopic pregnancy in the past 12 mg Month Year been signed by the atte should be detached for Day 4 Pregnant at time of death 5 Other (specify) 2 No P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion cause of death? 24a. Was an cate has page 2 s performed certificate 2 No 1 ☐ Yes 2. No 1 ☐ Yes To the Hospital or Attending Physician: "within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be ASSISTOP Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) LIVING 2 No 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Mann 1 Death 1 atural 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 ☐ Pending investigation 1 Tes 2 No 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie

State Registrar

DHMH 17 Rev 1/2001

30. Name and

31. Date

address of person who completed

ysician	1 - State Registrar	yland / Departmer <i>Certifica</i>	te of Death		Reg. No. 2 U U	0063
, cician	1. Decedent's Name (First, Middle, Last)			2. Date of Dea Month	ith Day Year	3. Time of Death
Medical	Henrietta Louise Jones				09, 2010	7:25 A ^N
caminer	4a. Facility Name (If not institution, give street and number)	4b. City	Town, or Location of Dea	ath	4c. County of Death	
	6020 Jamina Downs 5. Social Security Number 6. Sex 7. Age (1)		olumbia riYear If Under 24 Hi	s. 8. Date of Birtl	Howard	place (State or Foreig
neral	1 M 2 T F	91 Yrs. Months		n. (Month, Day	v, Year) Cou	intry)
ector	265-22-1903 Usual Residence of Decedent	71		10/14/1	919	'A
=		Oc. City, Town or Location				10d. Inside City Limits
led a	77	~ 1 1 1				1∭Yes 2☐ No
Director	MD Howard 10e. Street and Number	Columbia 10f Zi	p Code		10g. Citizen of What Cou	intry?
<u>a</u> <u>i</u> <u>o</u>						,
era	6020 Jamina Downs 11. Marital Status 12. Was Decedent Eve		.045	(Specify Yes or No-	USA 14. Race - Amer	ican Indian
or other traumatic event, The Medical Examinat must be notified at	Armed Forces? 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:	If Yes, spe	edent of Hispanic Origin? ecify Cuban, Mexican, Pue 2X No Specify:	erto Rican, etc.)	Specify:	
Completed	15. Decedent's Education	16a. Decedent's Usu	ual Occupation		16b. Kind of Business/I	
음	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give kind of wo	ork done during most of w use retired)	orking		
l e	4	Home	Maker		Own Home	
Be C	17. Father's Name (First, Middle, Last)	· · · · · · · · · · · · · · · · · · ·	18. Mother's N	ame (First, Middle,	Maiden Surname)	
To B	Joseph Edwards		Irene	Ke11 u		
	19a. Informant's Name/Relationship (Type. Print)	19b. Mailing Addres	s (Street and Number or		er, City or Town, State, Z	ip Code)
1	Irene Closson / Daughter	6020 Tamis	na Downs Col	umbia MI	210/5	
		20b. Place of Disposition (Na cemetery, crematory or		Date	20c. Location - City or T	own, State
	A Buriai 2 Cremation 3 C Removal from State		i			
ณ์	21. Signature of Euneral Service bicensee	St. Johns Cem			Ellicott Ci	2
once.	A Comment	72	L.	atimore F	uneral Serv	ices, PA
	23a. Part 1. Enter the disease, or complications that caused the		ent Town Dr			
٠	shock, or heart failure. List only one cause on each line. Immediate Cause (Final	John De Herenter the He	as or aying, cash as sara	as s. respiratory at		Approximate Interval Between Onset and Death
an :al	disease or condition a.	ementia				
ai er	Due to (or as a co	onsequence of):				
	Sequentially list conditions, if any, leading to immediate Due to (or as a co	onnoguonoo of\:				
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Examiner	Cauce (Diceace or highly that initiated events resulting in death) Last Due to (or as a co	onsequence of):				
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Me	IF FEMALE: 23c. If yes, outcome of p	oregnancy				
	in the past 12 months?	Fetal death 3 Ectopic			23d. Date of deli Month	very Day Year
<u> i</u>	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	ne of death 5 \sum Other (s	pecify)			
siciar	91 (Unknown					
Physician/Medical	9 Li Unknown	of resulting in the underlying	cause given in Part I	23e. Did to	bacco use contribute to	the cause of death?
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þ	9 Li Unknown	, ,	cause given in Part I.		obacco use contribute to res 2 ☐ No 3 ☐ Pro	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death **Physician** lacer Jan. /Medical 4b. City, Town, or Location of Death Examiner Baltimore atonsville 9. Birthplace (State or Foreign Country) If Under 24 Hrs. If Under 1 Year n yrs. last birthday) **Funeral** Months Days 1 □ M 2 🕦 F Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State ed other than "natural", or items 23a or 28a-f show event, the Medical Evanitum must be mailfied at 1 Nes 2 No **Funeral Director** MD to more 10g. Citizen of What Country? 21229 USA 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 72 hours after 1 Never Married 2 Married 1 □Yes 2 No Baltimore, Maryland 21215-0036 Specify 2 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "r any injury or other traumatic event, IT a Med any injury or other traumatic event, IT a Med app. 9 gnose. Elementary/Secondary (0-12) College (1-4or 5+) lerk her's Name (First, Middle, Maide (First, Middle, Last) Be argar ۵ Informant's Name/Relationship (Type. Pintaughter 19b. Mailing Address (Street and Number Margaret 20b. Place of Disposition (Name of cemetery, crematory or other) 20a. Method of Disposition Mikesville, MD 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Liver 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final ZHE1 Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Box 68760, physician Physician/Medical the as attending IF FEMALE: use 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months?
1 Yes 2 No for 5 Other (specify) P.0. the been signed by t should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 Mo 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy perform 1 ☐Yes 2 ☐ No 1 🗌 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death After t To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After 1 Natural 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident filled in by the 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier V59107 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) REISTERSTOWN MD 21136 DRAVE BUSINESS CENTER 31. Date filed (Month, Day, Year) 2. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

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Beorge Janssen		ment of Health and Mental H	ygiene 2010	0064
	Registrar	icate of Death	Reg. No.	
Physician Medical Examine	George Joseph Janssen		Date of Death Month Day Year January 7, 2010	3. Time of Death 0525 hrs
)	Aa. Facility Name (if not institution, give street and number) Northwest Hospital Center	4b. City, Town, or Location of Death Randallstown	4c. County of Deat Baltimore Cou	
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last	birthday) If Under 1 Year If Under 24Hrs		
Director	212-26-9468 1XM 2 F 83	Yrs. Months Days Hours Min	April 13,1926 Co	^{gn} ^{ountry)} Mary1and
λ.	Usual Residence of Decedent 10a. State 10b. County 10c. City, To	wn or Location		10d. Inside City Limits
d low any	Md. Balto.	Owings Mills		1 Yes 2 X No
the Maryland a or 28a-f show iffed at once.	10e. Street and Number	10f. Zip Code	10g. Citizen of What Cou	ntry?
th the Maryland 23a or 28a-f sho notified at once	120 Church Road	21117	USA	
or items 23	11. Marital Status 1 XNever Married 2 Married Armed Forces?	13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto		ican Indian, Black,
0 , 5	1 3 Widowed A Thyorced III Yes, Give Year	1 Yes 2 X No specify:	Specify: Wh	ite
urs aft itural" amine	lor Dates:	Sa. Decedent's Usual Occupation (Give kind of v	vork done 16b. Kind of Business/	Industry Recreation
5-0036 led within 72 hours al yigiene. other than "natural the Medical Examin	Elementary/Secondary (0-12) College (1-4 or 5+)	during most of working life. DO NOT use reti	iou)	alto. City
within siene.	3rd 17. Father's Name (First, Middle, Last)	Groundskeeper	(First, Middle, Maiden Surname)	
			A. Novak	
		19b. Mailing Address (Street and Number or F	Rural Route Number, City or Town, State	e, Zip Code)
e, MD I and 2 sho Health and item 27 is		84 Laurel Path Ct. 1	Nottingham, Md. 21 Date 20c. Location - City or	236 Town State
O 를 플 필입	1 X Burial 2 Cremation 3 Removal from State crem	matory or other place)	l-2010 Parkville,	
Baltimo permit. Page Department of Important:	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee		nimunek Funeral Ho	
Dep Dep Inju	Busing Weller	9705 Belair Ro	d. Nottingham, Md.	
Physician	23a. Part I. Enter the disease, or complications that caused the death. Do failure. List only one cause on each line.	o not enter the mode of dying, such as cardiac o	r respiratory arrest, shock, or heart	Approximate Interval Between Onset and
Examiner	Immediate Cause (Final disease or condition resulting in death) a. Hypertensive Atherosclero Due to (or as a consequence of):	otic Cardiovascular Disease		Death
	Sequentially list conditions, b			
iner iner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause Circumstate in the state of the control of the co			1
ted hist	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
execur.	LINPENDED			
on of Vital Records, P.O. Box 68760, ending Physician: The law requires that the death certificate be eath or: After this certificate has been signed by the attending physicia the funeral director, page 2 should be detached for use as the buriation: To Be Committed by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the		23d. Date of deliver	
Box 68760, e death certificate b the attending physical for use as the but we significant Merician Mer	past 12 months? 1 Live birth Pregnant at time of	 Fetal death 3 Ectopic pregna Other (Specify) 	incy Month	Day Year
Boy le death the att	1 Yes 2 No 9 Unknown 9 Unknown			
P.O.		lting in the underlying cause given in Part I.	23e. Did tobacco use contribute to 1 Yes 2 ✓ No 3 Prol	pably 4 Unknown
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Records, The law requires freate has been signage 2 should be Completed			autopsy prior to death? 1 ✓ Yes 2 No 1 ✓ Yes	completion of cause of
tal Recipion: The certificate rector, page		26 Place of Death (Check		2 10
Vit;	1 Yes 2 No Inpatient 2 V ER		g Home 5 Residence 6 Othe	r:
Division of Vital Records, tal or Attending Physician: The law requir rs after death al Director: After this certificate has been sited in by the funeral director, page 2 should be refification: To Re Completed	27. Manner of Death 28a. Date of Injury (Month, Day,Year) 28 Date of Injury (Month, Day,Year)	8b. Time of Injury 28c. Injury at Work?	28d. Describe how injury occurred	
5 Py 2 Py	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home	e, farm, street, factory, office building, etc.	28f. Location (Street and Number or Ru	ıral Route Number, City
Division o Division o Hospital or Attending A hours after death Funeral Director: After and filled in by the funeral or certification:	Suicide 6 Could not be determined (Specify)		or Town, State)	
To the Ho within 24 To the Fu completel	and manner stated. 29b Signature and title of certifier	29c. License number	29d. Date signed (Mo	
	James Bruthall ma	O.C.M.E.	January 8, 2010	
	30. Name and aedress of person who completed cause of death (Item 23		AD 24204	- -
Stat	Pamela E. Southall, MD Assistant Medical Exami 31. Date filed (Month, Day, Year) 43. Registrar's Signature	ner 111 Penn Street, Baltimore, M	MD 21201	
Stat Registra	that a disease of	have		
			00145	

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 19a nerth 8899 1/26/10 TT

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Amend 19a nerth 8899 1/26/10 TT For State Registrar Certificate of Death Reg. No. _ 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 01 2016 Shella ing /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 5. Social Security Number 6. So 8. Date of Birth 9-23-1947 Birthplace (State or Foreign Country) Year 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M 2 □ F MD 62 212-44-8520 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Ite Markel Eventment in the natified at 10a, State 1 Yes 2 No Director Baltimore MD na 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U S Α 21206 5607 Daywalt Avenue Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: Never Married 2 Married Black Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify. Specify: þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Disabled Disabled 2 years 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Miles Mae Girtrude Leon Keeling ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sherran & Name/Retation the Type. Print) Balto, MD 21237 2206 Hamilton Circle Sherran Griff Cousin Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State King Memorial Pk 1-15-10 Randalstown, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility March East F/H 21. Signature of Funer Service Licensee 1101 E. North Avenue Balto, MD 21202 Bran ~ Myle 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 20 days **Physician** PARUMONIA /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) P.O. Box 68760, certificate has been signed by the attending physician rector, page 2 should be detached for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Dav Year 5 Other (specify) ☐Yes 2 XNo 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Tyes 2 No 3 Probably 4 Unknown mitral Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 DKNo 1 ☐ Yes 1 □ Yes To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No 1 Minpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certif 69996082 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) essica Hoover MD Boltrmere GREENE ST 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JAN 15 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 Cole 9:35 A. The lma Kirks January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Hospice Care Towson **Baltimore** 5. Social Security Number If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Oct. Pay, . Yell 921 1 M 2 X F Months Hours 88 Maryland Director 21**7-**16-1422 Usual Residence of Decedent or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shon any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c, City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2X No Maryland Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 204 E. Joppa Road Apt. 21286 U.S.A 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12, Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White Completed 3 X Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 years Purchasing Agent Assistant Insurance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Dewey Cole Lillian Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6 Skipwith Green Richmond, Virginia James M. Cole (nephew) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🕅 Burial 2 □ Cremation 3 □ Removal from State Parkwood Cemetery 4 Donation 5 Other (Specify) 1-18-10 Baltimore, Maryland . Signature of Funeral Service Licensee 22, Name and Address of Facility Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road Baltimore, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Myocardia Inforction disease or condition resulting in death) Medical Due to (or s a consequence of Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Cause (Disease or linjury attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 X No Month Day Year 1 Yes 2 9 Unknown signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 □ Probably 4 □ Unknown 1 \square Yes cate has been sig Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy perform certificate 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 X No Other: 4 Nursing Home 5 Residence 1 🗌 Yes |은 6 X Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 1 Natural 28b. Time of 28c. Injury at 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation Accident Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

To the Hospital or Attending Physician: The law requires that the death certificate be executed eral Director: After this filled in by the funeral di within 24 hours a

Certificate: Medical

29a, Certifie

(Check

3 🗖

29b. Signature and title of certifier

State Registrar

Date filed (Month, Day,

address of person who completed cause of death (Item 23a) (Type, Print) UES

DECertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

on

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 5:05 P^{M} 2010 June Arbutus Kerns January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Dundalk Heritage Nursing Center If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 06/25/1923 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Hours Days Min 1 M 2 F West Virginia 233-34**-**6089 86 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 1 ☐ Yes **XX**No Director White Marsh Baltimore Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21162 U.S.A. 5845 Loreley Beach Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 25 If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2XXV0 1 ☐ Yes XXNo Specify δ Specify: 3 Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home 8 Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Blanche Bohrer Edgar Whitacre မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5845 Loreley Beach Road, White Marsh, Md. 21162 Patsy C. Didwall (Daughter) Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 01/16/2010 | Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Gardens of Faith 22. Name and Address of Eacility
Bruzdzinski Funeral Home, P.A. 21. Signature of Funeral Service Licenses 1407 Old Eastern Avenue, Essex, Maryland 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock or heart failure. List only one cause on the line. Approximate Interval Betwee Immed e Cause (Final dise e or condition resuling in death) hysician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) be executed that initiated events resulting in death) Last Due to (or as a consequence of): burial Box 68760 physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate the nding p as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregn in the past 12 mor 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Year Month Day 5 Other (specify) P.O. 9 Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I of Vital Records, 9 3 Probably 4 ☐ Unknown 1 ☐ Yes Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe certificate 1 ☐Yes 2 ☐ No 1 ☐ Yes 25. Was case referred / medical examiner? Be 26. Place of _ath (Check only one) Hospital: Other: 4 Uvursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this After thi funeral of 27. Mann of Death 28a. Date of Injury (Month, Day, Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Vatural 5 Pending investigation 1 ☐ Yes 2 ☐ No ours after death neral Director: / filled in by the fo death. 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral Completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifie

State Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

34. Aparticular Standard Standa

7. Age (In yrs. last birthday)

10c. City, Town or Location

70

Was Decedent Ever in U.S. Armed Forces?

2 🗌 No

KOUTZ

1 Yes 2 If Yes, Give Year or Dates:

College (1-4 or 5+)

4b. City, Town, or Location of Death

If Under 1 Year | If Under 24 Hrs.

Hours

13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Specify

(Give kind of work done during most of working life. DO NOT use retired)

Baltimore City

Days

10f. Zin-Code

1 ☐ Yes 2 🕱 No

Whitely

16a, Decedent's Usual Occupation

Hichitectural

17204

20b. Place of Disposition (Name of

cemetery, crematory or other place)

1030 AM

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 ☐ Yes 2 No

manland

2010

10g. Citizen of What Country

Race - American Indian. Black, White, etc.

White

altimore, mo

nitec

Specity:

Kar bowski

Monkton, MD 21111

16b. Kind of Business/Industry

8. Date of Birth (Month, Day, Year)

18. Mother's Name (First, Middle, Maiden Surname)

F.

Anna

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

15/2010

March 25, 1939

Directo

Funeral

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Completed

Be

2

1 - For State Registrar

Kaymona

5. Social Security Number

218-36-543

10e. Street and Number

17204

11. Marital Status

Patricia

20a. Method of Disposition

Usual Residence of Decedent

1 Never Married 2 Married

3 Widowed 4 Divorced

Elementary/Secondary (0-12)

17. Father's Name (First, Middle, Last)

19a. Informant's Name/Relationship (Type. Print)

4 ☐ Donation 5 ☐ Other (Specify)

21. Signature of Funeral Service Licensee

4a. Facility Name (If not institution, give street and number)

1 X M 2 □ F

Itimore

Calvin

15. Decedent's Education (Specify only highest grade completed)

1 🗷 Burial 2 🗌 Cremation 3 🗌 Removal from State

The Johns Hopkins Hospital

Physician /Medical **Examiner**

attending physician and Division of Vital Records, P.O. Box 68760,

shock, or heart failure. List only one cause on each line Immediate Cause (Final Due to (or as a consequence of): disease or condition resulting in death) emia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-transit melanoma Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant Live birth 2 Fetal death 3 - Ectopic pregnancy in the past 12 months? 4 🗌 Pregnant at time of death 5 Other (specify) 2 🗌 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 9 Completed 24a. Was an After this certificate has 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? Be Hospital: 1 Inpatient Other: 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 4 Nursing Home မ Date of Injury (Month, Day Year) 27. Manger of Death 28b. Time of Certification: 5 Pending investigation Injury 1 Natural 1 Tes 2 🗌 No 2 Accident Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier (check only one) and manner stated. 29c. License number 29b. Signature and title of certifier mp PES- 000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) m 600 North Wolfe St, Baltimore, MD, 21287 An ans 208120 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature Registrar

22. Name and Address of Facility Chapei & Cremation Services
Fuans Funeral Chapei & Cremation Services
16924 York Road Monkton Maryland 21 Road Monkton Maryland 2111 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 Yes 2 No 26. Place of Death (Check only one) 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, 1 Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 11 2010 Januany

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 1000 Jan 2010 /Medical 4a. Facility Name (#not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Howard County General Hospital Columbia If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, **Funeral** Year) Months Days Hours Min. 1/2 M 2□ F Yrs. 80 215-78-5229 Director November 15,1929 Korea Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2xxNo Columbia Maryland Howard 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 6213 Light Point Place 21045 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □Yes 2 ၨੱNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No If Yes, Give Year or Dates ģ Specify: 3 Widowed 4 Divorced Asian Completed 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Mechanic Trucking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Bo Young Kim Agnes Ju 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13313 Royden Court Ellicott City, Maryland 21042 Helen Yi (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Crestlawn Memorial Gardens: 1-14-2010 Marriottsville, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Eacility Witzke Funeral Homes, 1 5555 Twin Knolls Road Inc. Columbia, Maryland 21045 23a. Parl 1. Enter the discuss, or comstock, or heart failure. List only Approximate Interval Between Onset and Death or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line Immediate Cause (Final disease or condition resulting in death) **Physician** Vilyo Carde hours /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, bearing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner bus to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed P.O. Box 687600 Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 → hknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an mentia certificate 1 □Yes of Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes No Other: 4 Nursing Home Hospital Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) the funeral 27. Manner of Death Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After Division 1 Natural 2 Accident 5 ☐ Pending investigation death. 1 ☐ Yes 2 ☐ No after death 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined completely filled in by 4 ☐ Homicide Hospital within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. 29b. Signature and title of Cortifier

Registrar
DHMH 17 Rev 1/2001

State

30 Name and address of per

31. Date filed (Month, Day, Year,

Sa

Vater

son who completed cause of death (Item 23a) (Type, Print)

32. Registrar's S

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3.30 P M Physician/ Charles W. Krantz ANUAR Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Deat BAUTIMORE WACHINGTON MEDICAL GENTER If Under 24 Hrs. Hours Min. If Under 1 Year 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Months July 26. 930 Pennsylvania Director 185-24-1374 79 Usual Residence of Decedent or 28a-f show 10b. County 10c, City, Town or Location injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director Maryland Anne Arundel 1 🗆 Yes 2 🙀 No Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? other than "natural", or items 23a 211 Ditty Ct 21060 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. per it. Page 1 and 2 should re filed within 72 hours after De, artment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or any injury or other transmiss. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates.49-53 1 ☐ Yes 2 🕱 No Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Business Owner Self Employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles W. Krantz Anna Weber 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth A. Krantz/ Wife 211 Ditty Ct., Glen Burnie, Maryland 21060 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State an. 2010 Donation 5 Other (Specify) Crownsville MD. Vet. Cem. Crownsville, Maryland 21. Signal re of uneral ervice Lice see 22. Name and Address of Facility Kirkley-Ruddick Funeral Home PA 421 Crain Hwy. S.E. Glen Burnie MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dving, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ META disease or condition resulting in death) BOULC Medical Due to (or as a consequence of): Examiner Samuentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury ending physician and use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No certificate has been signed by the atte irector, page 2 should be detached for Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 1 Yes 2 No Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 - No Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work?
1 ☐ Yes 2 ☐ No. 1 🗹 Natural injury 5 Pending ☐ Accident ☐ Suicide Investigation ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signat 29c. License number 045149 impleted cause of death (Item 23a) (Type, Print) address of person who co 10 31. Date filed (Month, Day, 32. Registrar's Sig State

Registrar

			For State	State of Marylan		artment of H		-	201	0 0061.7
			Registrar 1. Decedent's Name (First, Middle, La	ast)	061	incate of L	Jeau I	2. Date of Dea	Reg. No. 4 U	3. Time of Death
	Physicia Medic		Arlene	Chambers		Lee		January	$7 10^{9}, 2010^{9}$	
	Examir	ner	4a. Facility Name (if not institution, giv Southern Marylan	,		4b. City, Town, or Clintor		ath	4c. County of De	eath George's
	Funeral Director		230-64-8880	Sex 7. Age (In yrs. In 1 M 2 F 89	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir			Birthplace (State or Foreign Country) rginia
Baltimore, Maryland 21215-0036	ge 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. It fitem 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	Completed by Funeral Director	Usual Residence of Decedent 10a. State 10b. County MD Prince 10e. Street and Number 7520 Surratts Ro 11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's (Specify only highest g	George's C1: ad 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 內 No If Yes, Give Year or Dates. Education	16a. Deced (Give I life. Do	10f. Zip Code 20735 Was Decedent of H f Yes, specify Cuba ☐ Yes 2 ☑ No lent's Usual Occup find of work done of D NOT use retired) hen Aide	Specify:	rto Rican, etc.)	10g. Citizen of What USA 14. Race - Ar Black, WI Specify: B 16b. Kind of Busines School Ca	nerican Indian, nite, etc. lack s Industry
and	e filed ntal Hy ed ott	To Be	17. Father's Name (First, Middle, Last) Percy Chambers				ame (First, Middle, i	,		
ž	ould b nd Mer mark matic		19a. Informant's Name/Relationship (Type Print)	10h Mailin	- Address (Ctrast		e Chamber		
Š	d 2 shall ar alth ar 27 is		Howard A. Lee, J					per Marll	City or Town, State, .	215 Code) 20772
ore,	of Hear of Hear of item		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	20h P	lace of Disno	sition (Name of	- ; · ·	Date	20c. Location - City	or Town, State
<u>Ť</u>	t. Page tment o tant: If jury or		4 Donation 5 Other (Spec	ify) Mou	rner's hurch	natory or other place Valley f Cemetery	Sapt 1-	15-10	Dillwyn,	Virginia
Ba	permit. Page 1 Department of Important: If i any injury or o		21. Signatur of Funeral Service Licer	isee	22	Reid's F P.O. Box	s of Facility Funeral 247 Di	Home 11wyn, V	A 23936	
	Medical Examiner	er.	23a Part 1. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions,	a Due to (or as a consequ	end of:	r the mode of dying	g, such as cardia	ic or respiratory arm	est,	Approximate Interval Between Onset and Death
09,	ate be e hysicia: he buri	edical Examiner	If they, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last	c						
. Box 68	sictans. The law requires that the death certifica certificate has been signed by the attending princtor, page 2 should be detached for use as in rector, page 2 should be detached for use as it.	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 morths? 1 ☐ Yes 2 ☐ No g ☐ Unknown	23c. If yes, outcome of pregnar 1 ☐ Live Birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	Ideath 3	Ectopic pregnance Other (specify)	у		23d. Date of o	lelivery Day Year
s, P.O	law requires that the nas been signed by the 2 should be detach	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute 1 Yes 2 No 3							to the cause of death?
Division of Vital Records,	he law requite has beer age 2 should	Completed	Ŋ	entra				24a. Was a autope perfor	med? prior to death?	
<u> </u>	ertifica ctor, p		25. Was case referred to medical examiner?			26. Pla	ice of Death (Che		2 □ No 1 □ Y	es 2 No
<u> </u>	Physic this or al dire	욘	1 ☐ Yes 2 ☐ No 27. Manner Death	Hospital: 1 ☑ Inpatient 2 ☐ I 28a. Date of injury	ER/Outpatient		4		ence 6 Other (Spe	ecify)
o uo	anding sath. ir: After	Certificate:	1 atural 5 Pending 2 Accident Investigation	(Month, Day, Year)	injury	28c. Injury work: M 1 1	at ? Yes 2 □ No	28d. Describe ho	w injury occurred	
DIVISI	al or Afters al Directo		3 Suicide 6 Could not to determined			et, factory, office		28f. Location (St City or Town	reet and Number or R , State)	ural Route Number,
	to the Nospital or Attending Physician; the la within 24 hours after death. To the Funeral Director, After this certificate he completed filled in by the funeral director, page.	Medical	(Check 2 Medical Exam	rsician: To the best of my knowle niner: On the basis of examination se Practioner: To the best of my	and/or investi-	gation, in my opinio	n, death occurred	at the time, date an	d place, and due to the	cause(s) and manner stated.
	vith Co t		29b. Signature and title of certifier	ah m		29c. License	number	1	9d. Date signed (Mon	
			30. Name and address of person who	completed cause of death (Item	23a) (Type, Pr				111-1	22902
	01-01		A 1. ILEZAZAD 31. Date filed (Month, Day, Year)	EH MO. 986	o ac	orgin	Ave 3	Te 312	silver sf	N-ZMO
	Stat Registra	_	JAN 15		A. A	arkel				•

DHMH 17 Rev 7/2009

10-00308 UNK UNK Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2010 0648

THIC OTHIC		1- For State Registrar	Certificate			2010	00040				
Physic ¶edical Exam		Decedent's Name (First, Middle,Last)	Date of Dea Month								
)		4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Location	January 1	1, 2010 4c. County of Death	1040 nrs				
		Outer Loop of 695 @ Rt. 40		Catonsville		Baltimore Cour	-				
Funeral Director		5. Social Security Number 6. Sex 7. Ag 278-71-6735 1 1 1 1 Am 2 F	je (In yrs. last birthday) 29	Months Days Hour		rth (MM/DD/YYYY) 9. Birth /1980	nplace (State or ntry)Honduras				
		Usual Residence of Decedent		/rs.	04/03/	71900 Cod	miry)HOHQUL as				
Ow any	l	10a. State 10b. County 10c. City, Town or Location 10d. Ir MD N/A Baltimore 1									
Maryland 28a-f show d at once.	Director	10e. Street and Number		Baltimore 10f. Zip Code		1 X Yes 2 No 10g. Citizen of What Country?					
h the M 3a or 2 otified	Dir	4 Amleht Court T3		21215		Honduras					
ath wit items 2 ist be n	nera	11. Marital Status 1	·	Was Decedent of Hispanic Or f Yes, specify Cuban, Mexical	igin? (Specify Yes or No n, Puerto Rican, etc.)	14. Race - America White, etc.	an Indian, Black,				
after de al", or	by Fun	3 Widowed 4 Divorced If Yes, Give Year or Dates:		X Yes 2 No specify		Specify: His	panic				
2 hours "natur Exam	ted		during	ent's Usual Occupation (Give most of working life, DO NOT		16b. Kind of Business/Ind	dustry				
036 ithin 7. me. r than	Completed	3	·	scape Foreman		Landscapi	ng				
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	S				r's Name (First, Middle, I	,					
212 ould be I Mentz s marks ic even	To Be	Eliceo Manchame-Ramires 19a. Informant's Name/Relationship (Type, Print)	19b. Maili	ing Address (Street and Nur	ana Leon-Ce	nber, City or Town, State, 2	Zip Code)				
MD and 2 sho alth and 2 is raumati		Odilio Manchame-Leon (Brot	her) 6948	Brookmill Ro	oad B-1, Bal	ltimore, Mar	yland 21215				
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygient Incompanies of Health and Mental Hygient Ameria Wastural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		1 X Burial 2 Cremation 3 Removal from Sta	ate crematory or o	osition (Name of cemetery, other place) Cemetery	Date	20c. Location - City or To					
altin mit. Pa partmer portan ury or		21 Signature of Funeral Service Licensee	_1	Name and Address of Facilit		Quebracho, I Funeral Home					
		220 Bart I Felor the disease of the live in the	4	1107 Wilkens A	venue, Balt	imore. Marv	land 21229				
Physician /Medical		Part I. Enter the disease, or complications that caused failure. List only one cause on each line. Immediate Cause (Final disease a Multiple Injuries	ne death. Do not enter	the mode of dying, such as o	ardiac or respiratory arre	est, shock, or heart	Approximate Interval Between Onset and Death				
Examiner		or condition resulting in death) Due to (or as a conse	quence of):								
	ner	Sequentially list conditions, if any, leading to immediate b. Due to (or as a conse	quence of):								
. 21	camir	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):									
cecuted cecuted . transit	al E	d									
50, te be er nysiciar burial	ledic	UNPENDED X AMENDED 1 FFEMALE: 23c. If yes, outcome	1 as noted	per ME g899	1/20/10 TT	Look Data Calar					
68760, certificate be nding physici se as the buri	ian/N	23b. Was decedent pregnant in the past 12 months? 1 Live birth Pregnant at t	2 🗌 F	etal death 3 Ectopic	pregnancy	Month Day	/ Year				
Box t death c the atten ed for us	Physician/Medical Examiner	1 Yes 2 No 9 Unknown 9 Unknown	5 C	Other (Specify)							
Vital Records, P.O. Box 6876 hysician: The law requires that the death certificathis certificate has been signed by the attending pill director, page 2 should be detached for use as the	by P	Part II. Other significant conditions contributing to death	but not resulting in the	underlying cause given in Pa	I —	bacco use contribute to the					
rds, require been sig	eted				24a. Was a		osy findings available				
Reco	Completed				autops perform	med? death?	pletion of cause of				
tal R	BeC	25. Was case referred to medical examiner?		26. Place of Death		1 10	2 10				
Sion of Vital Records, Attending Physician: The law require retor: After this certificate has been si by the funeral director, page 2 should b	유	1 V Yes 2 No				Residence 6 Other: S	cene				
_ = . \2	ation	27. Manner of Death 1 Natural 5 Pending 2 ✓ Accident Investigation 28a. Date of Injuny (Month Day Yes) Jan 11, 2010	1000 hrs	1 Yes 2	Pedestrian s	truck by auto					
Division pital or Attendir ours after death.	Certification:	3 Suicide 6 Could not be 28e. Place of Inju		eet, factory, office building, etc	or Town, St	treet and Number or Rural ate)					
fig on bi		4 Homicide (Specify) Major 29a. Certifier 1 Certifying Physician: To the best of my	or Road / Highway			695 @ Rt. 40, Catonsvi	ille, MD				
To the Hos within 24 h To the Fun completely	Medical	one) 2 Medical Examiner: On the basis of examinand manner stated.	ination and/or investiga	ation, in my opinion, death occ	curred at the time, date a	nd place, and due to the c					
	2	29b-Signature and Iffle of certifier	1/2084	29c. License number O.C.M.E.		29d. Date signed (Month, January 12, 2010	Day, Year)				
8	ŀ	30. Name and address of person who completed cause of dea	ath (Item 23a)								
		Victor Weedn MD JD Assistant Medical E		Penn Street, Baltimore	, MD 21201						
St: Regist	ate	31. Registrar's	Signature								

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea No 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2 Date of Death Month **Physician** Year LINTZ P:15 January -4Lille 2010 TL /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Johns HODKINS Baltmore Bayview Medical Center Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, **Funeral** Months Days Hours 278-03-5756 Director 92 May 17, 1917 Kentucky Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits Director Maryland Baltimore Dundalk 1 □Yes 2 📉 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21222 USA 8205 Gray Haven Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify. Specify: White ģ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Housewife Own Home 6 years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Samuel Berry Minnie Thompson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charlotte Markowski Daughter 1780 Melbourne Road, Dundalk, Maryland 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Januarv 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Middle River, Maryland Holly Hill Memorial 4 Donation 5 Dother (Specify) 15, 2010 Signature of Funeral Service Licensee Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 21222 omplications that caused the death. ontenter the mode of dying, such as cardiac or respiratory arrest, ally one cause on each line. 23a. Part 1. Enter the disease, or do shock, or heart failure. List on Immediate Cause (Final **Physician** 05 parator disease or condition resulting in death) /Medical Due to (or as consequence of) Examiner Glomeryon Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>გ</u> 4 👿 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Minpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manper of Death Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No 2 Accident

Hospital or Attending Physician: The law requires that the death certificate be executed As hours after death.

Euneral Director: After this certificate has been signed by the attending physician and eath, it is not the funeral precior. The page 2 should be detached for use as the burta-transit stely filled in by the funeral director, page 2 should be detached for use as the burta-transit Division of Vital Records, P.O. Box 68760 24 hours a within 24 ho

To the Fune

completely f

State

Medical

DHMH 17 Rev 1/2001

Eastern

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940

Could not be determined

3 Suicide

29a, Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifier

Ryan Childers, MID.

JUN 1-0 2010

31. Date filed (Month, Day, Year,

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

RE3-000

Baltimore

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Januar

21224

29d. Date signed (Month, Day, Year)

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For	State	of Marylar	_			nd Mental H	ygiene	10	00000
		1 - State Registrar			Cer	tificate of	Death		Reg. No. 4	<u> </u>	0.0650
Physic	cian/	1. Decedent's Name (First, Middle	,					2. Date of D Month	eath Day	Year	3. Time of Death
Med	dical	CHARLES		LEISU	RE			Jan		2010	5 T AM
Exam	iner				- 1	4b. City, Town,		Death	4c. Count	ty of Death	
<u>-</u>		JOHNS HOPLINS BI 5. Social Security Number	ANVIEW ME	7. Age (In yrs.		If Under 1 Year	If Under 24	Hrs. 8. Date of B	i-aklo	a piat	1 Di. A 5
Funera Directo		216-34-6709	6. Sex 1 ☑ M 2 ☐ F	7. Age (III y/s.	Yrs.	Months Days			937°1937	Mar Mar	place (State or Foreign Pland
	"	Usual Residence of Decedent		12			<u> </u>	TIP L L L	3,270.	1	(
and shov	ō	10a. State 10b. County		10c. Ci	ty, Town or Lo	cation				1	0d. Inside City Limits
Maryl Ba-f tified	0	Md. Ba	alto.		Esse	ex					1 ☐ Yes 2X☐ No
the t	٥	10e. Street and Number				10f. Zip Code			10g. Citizen of	What Coun	try?
s 23e	Funeral Director	418 Virginia A	Avenue			21	221			USA	
Z1Z13-UU30 within 72 hours after death with the Maryland glene. er than "natural", or items 23a or 28a-f sho er than "matural", it he Medical Examiner must be notified at the Medical Examiner must be notified at			12. Was Dece Armed Fo	edent Ever in U.	S. 13. V	Vas Decedent of I	Hispanic Origin'	? (Specify Yes or No uerto Rican, etc.)		ce - Americ	
affer affer (amir	٤	1 Never Married 2 X Marr	ied 1 🔀 Yes	2 No		☐ Yes 2 🔀 N		,		ack, White, e	
ours a	tec	3 Widowed 4 Divorced	Year or Da	ates.					-		
Z1Z13-UU36 within 72 hours after giene. er than "natural", o , the Medical Exam	į	(Specify only highe	st grade completed,	· · · · · · · · · · · · · · · · · · ·	i (Give I	lent's Usual Occu kind of work done O NOT use retired	during most of	working	16b. Kind of I	Business Ind	dustry
iene.	Completed	Elementary/Seconday (0-12)	College (1	-4 or 5+)	Mach		"		Wester	n Elec	ctric
IANG Z1Z13-UU30 be filed within 72 hours after death with the Maryland lental Hygiene. rked other than "natural", or items 23a or 28a-f show it event, the Medical Examiner must be notified at	a	17. Father's Name (First, Middle, L	ast)				18. Mother's	Name (First, Middle	e, Maiden Surnan	ne)	
Tan Tan I be f fenta rked ric ev	<u>ا</u>	Charles Wm. Le:	isure, Sr	•			Ada	May Clark	τ		
ore, Maryland 1 and 2 should be filed of Health and Mental Hy filtem 27 is marked oth		19a. Informant's Name/Relationsh	nip (Type, Print)		19b. Mailir	g Address (Stree	t and Number o	r Rural Route Numb	er, City or Town,	State, Zip C	Code)
		Jennifer Gibso	on	DTR.	510	Holly Hu	nt Road	Middle	River,	Md. 2	1220
of He		20a. Method of Disposition 1 ☐ Burial 2 🔀 Cremation			Place of Dispo	sition (Name of natory or other pla	ace)	Date	20c. Location	- City or To	wn, State
Page nent ant: I		4 Denation 5 Other (S			ayvíew		1-	14-2010	Balto.	Md.	
baltimore, permit. Page 1 and Department of Hea Important: If item	ej	21. Signature of Funeral Service L	icensee	W80.	22	. Name and Addr	ess of Facility	Schimunel	. Funera	1 Home	3,
D 997 2	ō	1 xux)-				9705 Bel	air Rd.	Notting	gham, Md	, 212.	36
		23a. Part 1. Enter the disease, or shock, or heart failure. List o	complications that only one cause on ea	caused the dea ach line.	th. Do not ente	r the mode of dyi	ing, such as car	diac or respiratory a	arrest,		Approximate Interval Between
Pnysicial	_	Immediate Cause (Final disease or condition	re mug to	CARD	IDISEN	ic SHO	ock			- 4	Onset and Death
Medica Examine		resulting in death)	Due to	(or as a conseq	uence of):						
=Xammi	•	Sequentially list conditions,	b. ———	Myo	CARDIA	INFA	ARCTION			_	10 bays
ed sit	Ä	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Due to	(or as a conseq	usnes cij:					1	
and I-tran	Examiner	that initiated events resulting in death) Last	c. Due to	(or as a conseq	uence of):					_	
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cate by	ğ		d								
oortifica certifica nding p	2	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out	tcome of pregn	ancy	1			23d. D	ate of delive	erv
death	icia	in the past 12 months? 1 Yes 2 No	4 Preg	nant at time of		Ectopic pregnar Other (specify) _	ncy			onth	Day Year
the d	Physician/Me	9 Unknown	9 🔲 Unki	nown							
that the	Ş	Part II. Other significant condition			sulting in the u	nderlying cause g	iven in Part I.	23e. Did	tobacco use cor	tribute to th	e cause of death?
dS, quires en sig	ğ	C. D. FEICI	LE INFE	ECTION				_ 1 [Yes 2 No	3 Prob	pably 4 Unknown
VILAII RECOIDS, ysician: The law requires is certificate has been sig director, page 2 should b	ompleted							24a. Wa	s an 24b.	Were autor	osy findings available mpletion of cause of
The late had page	S							per	formed?	death?	
sian: ertific ctor,	Be (26. F	Place of Death (Check only one)			
hysic his co	<u>ا</u>	1 ☑ Yes 2 ☐ No		Inpatient 2		t 3 🗆 DOA Oti	her: 4 \square Nursi	ng Home 5 🗆 Res	sidence 6 🗆 Ot	her (Specify))
ing P	ate	27. Manner of Death 1 ☑ Natural 5 ☑ Pendin	g 28a. Date (Mon	of injury th, Day, Year)	28b. Time of injury	28c. Inju woj	rk?	- 1	how injury occur	red	
ttend death tor: A	iji	2 Accident Investig	gation	21.1			Yes 2 No	_			
DIVISION OI al or Attending PI s after death. I Director: After the	Certificate:	4 Homicide determ	inad 28e. Place	of Injury - At hing, etc. (Specif		et, factory, office			(Street and Numi wn, State)	ber or Rural	Route Number,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit			Physician: To the b	est of my know	rledge, death o	occured at the tim	e, date and place	ce, and due to the o	ause(s) and man	ner as state	d.
e Ho	Medical	(Check 2 Medical E	xaminer: On the bas Nurse Practioner:	sis of examination	n and/or invest	igation, in my opin	ion, death occur	rred at the time, date	and place, and de	ue to the cau	ise(s) and manner stated.
withir comp	1	29b. Signature and title of certifier	1		,	29c. Licens		a place, and accept	29d. Date sign		
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Regis	trar	27.11 1 2 201	U Canes	w pt.	MOUNT	-					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Medical 4a Facility Name (if not institution, give street and number) b. City Town, or Location of Death **Examiner** 4c. County of Death Hospice of NW Hospital Kandallstown Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) 1 🗆 M 2 💢 F Director Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene.

27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director Baltimore saltimore 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 2 207 Featherbed Lane 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? þ Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Black Completed 3 Widowed 4 Divorced Specify: Year or Dates Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) scial Security Elementary/Seconday (0-12) College (1-4 or 5+) Clerk Administration Be 18. Mother's Name (First, Middle, Maiden Surname) Moore, Manizer imax 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh
Department of Health as
Important: If item 27 is
any injury or other tra Cervidae Randallstown M021133 20a. Method of Disposition 20b. Place of Disposition (Name of Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Baltimone, MD 4 ☐ Donation 5 ☐ Other (Specify) oudan Vaughn C. Greene Funcial SUCS Road Randall JOWN MD 01122 re of Funeral Service Licensee 22. Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or he had fillium. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, cause. Enter Underlying Examine Disk to for as a nonsequence of attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of). Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Jnknown Completed 24a. Was an 24b. Were autopsy findings available autopsy performed prior to completion of cause of hours after death.

Ineral Director: After this certific
d filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural iniurv 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined within 24 hours a
To the Funeral C
completed filled Medical l 🗲 certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of pertifier Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 4 201 Registrar DHMH 17 Rev 7/2009

ORIGINAL

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Physici		Natennia Pakenny 122 10 3010 10											
/Medic Examir		4a. Facility Name (If not institution, give s Union Memorial		4b. City, Town, or Locat Baltin		Location of Death	oun.	4c. County of Death					
Funeral Director		21. 02 32	7. Age (In yrs. la	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, July	3 , 1935 9. Birth	nplace (State or Foreign Intry) VA •				
Ba-f show	Director	Usual Residence of Decedent 10a. State 10b. County 10b. MD 10b. 10b. 10b. 10b. 10b. 10b. 10b. 10b.	Town or Lo	imore			10d. I						
23a or 2	al Dire	10e. Street and Number 1615 E. Chase S	t. Apt.204		10f. Zip Code 21213		1	Og. Citizen of What Cou USA	intry?				
Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Event fruit be notified at once.	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	I2. Was Decedent Ever in U.S Armed Forces? 1		Was Decedent of Hi If Yes, specify Cubar 1 □ Yes 2 ☑ No	spanic Origin? (Spen, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Black, White	14. Race - American Indian, Black, White, etc. SpecifyBlack				
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Mental F arked otl atic even	To Be	17. Father's Name (First, Middle, Last) Wade Cham	bers			Daisy		ddle, Maiden Surname) 11					
alth and 27 is ma er trauma		19a. Informant's Name/Relationship (Type Eugina R. Ford						r, City or Town, State, Z to, Md。 21	' '				
ment of He ant: If item ury or oth		20a. Method of Disposition 1 ⊠ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State 1	inity		ry Jan.	15/10 1	20c. Location - City or TBalto, Md.	own, State				
Depart Import any Inj once.		21. Agnature of Funeral Service Licensee 22. Name and Address of Facility Calvin B. Scruggs Funeral Home 1412 E. Preston St. Balto, Md. 21213											
physician and physician and the prival-transit	al Examiner	23a. Part 1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque	ence of):	ter the mode of dying	ovt di	Le O.J.	est,	Approximate Interval Between Onset and Death				
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After this e funeral d	Certification: To	27. Manner of Death 1. Natural 5 Pending 2 Accident investigation		28b. Time o Injury	f 28c. Injury Work	4 LI Nursing Hor		ence 6 Other (Specow injury occurred	ify)				
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ie Funera	Medical (29a. Certifier 1 Certifying Phys (Check only one) 1 Medical Examin	iclan: To the best of my knowner: On the basis of examination and marrier stated.	/ledge, deat on and/or in	h occurred at the time time of the street of	ne, date and place, pinion, death occurr	and due to the c ed at the time, d	cause(s) and manner as late and place, and due	stated. to the cause(s)				
To th	Me	29b. Signature and title of certifier	MD		29c. License	0 6 4 7 8	8 2	9d. Date signed (Month	, Day, Year) 2010				
2		30. Name and address of herson who con	mpleted cause of death (Item)	23a) (Type,	Print) MT. ROY	AL. AUE	BALT	INDE MD	21717				
Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signatu	ıre									

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 20b per FH 8899 1/29/10 TT

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 13,2010 Physician/ JÄNÜARY Vincent Edward Milan 7:38P M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death SAINT JOSEPH MEDICAL BALTIMORE CENTER TOWSON Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**X** M 2 □ F Days Hours Min Months Yrs Director 215-40-2821 Maryland ecember Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Md. Balto. Kingsville 1 ☐ Yes 2 🗶 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7509 Shipley Avenue 21087 USA within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. þ 1 Never Married 2 X Married 1 Yes 2 XNo Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify. White "natural" 3 Widowed 4 Divorced Specify: Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Self-Employed 12th Contractor other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic or Vincent W. Milan Eleanor McGreevy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7509 Shipley Avenue Kingsville, Md. 21087 <u>Marv J. Milan</u> Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of Date 2010 20c. Location - City or Town, State 1 💢 Burial 2 □ Cremation 3 □ Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) Bel Air Memorial $1 - 18 - \frac{2009}{}$ Bel Air, Md. 21. Sign have of Funeral Service Licenses 22. Name and Address of Facility Schimunek Funeral Home te 9705 Belair Rd. Nottingham, Md. 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ ISCHEMIC CARDIOMYOPATHY disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed -tran and Due to (or as a consequence of) nding physician a Physician/Medical Division of Vital Records, P.O. Box 68760 for use 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death signed by the at d be detached fo Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown MULTIPLE MYELOMA 1 🗌 Yes Completed should peen 24b. Were autopsy findings available prior to completion of cause of death? ACUTE RENAL FAILURE 24a. Was an page 2 s autopsy perform this certificate 2 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Hospital 1 🗌 Yes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After 1 Natural
2 Accident
3 Suicide (Month, Day, Year) injury 5 Pending work after death. Investigation 1 Yes 2 No completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined e Funeral C Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

within 2

the

(Check

only one

29b. Signature and title of certifier

FRANCIS

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M D

2010

7601

ar's Signature

32. Regist

KHOO,

JAN 15

OSLER

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

DRIVE TOWSON MARYLAND 21204

29d. Date signed (Month, Day, Year)

13-2010

29c. License number

D30263

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State of Ma	aryland / Depa			Mental Hyg	giene	00051
			Registrar 1. Decedent's Name (First, Middle, Last)	Death	Reg. No. 2010 000 J				
	Physicia Medic		George Nelson N	2. Date of Dea	Day Year 12 20				
4.1	Examin	er	4a. Facility Name (if not institution, give street and number) BWL+iMGZE VAMED icaLC	enter	1	r Location of Death		4c. County of Dea	ath
	Funeral Director			(In yrs. last birthday) 60 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birti		irthplace (State or Foreign ountry) MD
	nd how at	٦٢	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Lo	cation		102		10d. Inside City Limits
	Maryla 28a-f s otified	Director	MD na	Baltimo	ce				1 X Yes 2 □ No
	with the 23a or 1st be n	Funeral D	10e. Street and Number 244 N. Bethel Ct		10f, Zip Code 21	231		10g. Citizen of What C	country?
9036	s filed within 72 hours after death with the Maryland tal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	þ	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent E Armed Forces? 14. Wes Decedent E Armed Forces? 15. Wes 2 1 17. Yes, Give Year or Dates.		Was Decedent of H f Yes, specify Cuba I ☐ Yes 2 🌠 No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecity Yes or No- Rican, etc.)	14. Race - Am Black, Whi Specify:	
Maryland 21215-0036	within 72 hou giene. ner than "natu it, the Medica	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5-	+) (Give	O NOT use retired)	during most of work	sing	16b. Kind of Busines:	s industry
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ırylaı	should be and Menta is marked raumatic e	욘	George Theodore Montag 19a. Informant's Name/Relationship (Type, Print)	1	A -l-l (O44			eatrice N	
, Ma	1 and 2 should be file of Health and Mental I f item 27 is marked o r other traumatic eve		Kali Montague-daughter		-	Lane Fo		r, City or Town, State, Z th, Texas	76740
Baltimore,	Page 1 a nent of H int: If ite		20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Dispo cemetery, cren Greenmo	natory or other plac	ce) i	Date 4-2010	20c. Location - City of Baltimor	
Balti	permit. Page 1.8 Department of H Important: If ite any injury or ot		21. Signature of Funeral Service Licensee	22	Name and Addre	ss of Facility M	arch Ea Avenue	ast F/H Balto, M	D 21202
Ī			23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line.	the death. Do not ente	er the mode of dyin	ng, such as cardiac	or respiratory arr	rest,	Approximate Interval Between
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Box 68760	res that the death certific signed by the attending I d be detached for use as	Physician/M		2 Fetal death 3	Ectopic pregnand Other (specify)	cy		23d. Date of d Month	Day Year
ds, P.C	uires that I in signed b	by	Part II. Other significant conditions contributing to death bu	obacco use contribute f	to the cause of death? Probably 4 Unknown				
Division of Vital Records, P.O.	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. Within 24 hours after death. The Funeral Director: After this certificate has been signed by the attending completed filled in by the funeral director, page 2 should be detached for use as	Completed					24a. Was a autop perfor	osy prior to rmed?// death?	utopsy findings available completion of cause of
ta	ician: The certificate rector, pag	Be (25. Was case referred to medical examiner?			lace of Death (Chec			
of Vi	g Physi er this c eral dir	e: To	27. Manner of Death 28a. Date of injur	ent 2 ER/Outpatier y 28b. Time of	28c. Injur	y at UNursing H		dence 6 Other (Spe ow injury occurred	ecify)
ion	ttending death. tor: Aft the fun	Certificate:	1 ☑ Natural 5 ☐ Pending (Month, Day, 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be			Yes 2 No	00(1 11 60		15 1 11 1
Divis	To the Hospital or Attending Physician: The Is within 24 hours after death. To the Funeral Director: After this certificate his completed filled in by the funeral director, page		building, etc.				City or Tow		
	e Hospi 24 hou e Funer	Medical	29a. Certifier 1 Certifying Physician: To the best of r (Check only one) 3 Certifying Nurse Practioner: To the basis of ex	amination and/or inves	tigation, in my opini	on, death occurred a	at the time, date a	nd place, and due to the	e cause(s) and manner stated.
	To the within 2 To the comple	~	29b. Signature and title of certifier	Resident	29c. Licens	e number		29d. Date signed (Mon	th, Day, Year)
120			30. Name and address of person who completed cause of de	eath (Item 23a) (Type, F	Print)		^	Jan 10 inore, MD	2, 2010
Ł	Sta	0	31. Date filed (Month, Day, Year) 2010 P. Registra	r's Signature	Rth O-Re.	eac Stree	+ Balt	more, MD	21201
	Registra	ar	JAN 15 2010 22. Registral	P. 190					

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Physician/ 2010 Willie McRae Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore n/a Frank Lorien If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** (Month, Day, Year, 4-21-19 Days Hours Min Country) 1 X M 2 - F Yrs. 193 Director 250-58-8419 Usual Residence of Decedent 10d. Inside City Limits 23a or 28a-f shov 10b. County 10c. City, Town or Location 10a. State be filed within 72 hours after death with the Maryland event, the Medical Examiner must be notified at Director X Yes 2 No Baltimore MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 21206 S 6034 Amberwood Road Apt c 1 U Α or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Black "natural", 3 Widowed 4 Divorced Completed Year or Dates 16b. Kind of Business Industry unk 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Laborer 12th grade Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be 1
Department of Health and Menta
Important: If item 27 is marked
any injury or other traumatic ev
once. ပ David McRae Sabre 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diane Goines-Former Spouse 5449 Bucknell Road Balto, MD 21206 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1/14/2010 1 Removal from State 1-10-2010 Arbutus, 4 ☐ Donation 5 ☐ Other (Specify) Arbutus Memorial 22. Name and Address of Facility March East F/H Signature of Funeral Service Licensee 1101 E. North Avenue Balto, MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ASCUD Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examine Sequentially list conditions. Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed is certificate has been signed by the attending physician and director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? 5 Other (specify) Pregnant at time of death 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Tyes 2 No 3 Probably 4 Winknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed Yes 2 death? 2 No After this certificate I 1 🔲 Yes 26. Place of Death (Check only one) Be 25. Was case referred to medica examiner? Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) completed filled in by the funeral 28a. Date of injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Certificate: (Month, Day, Year) injury 5 Pending 1 🖪 Natural 1 Tyes 2 No М Accident Investigation after death 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a To the Funeral I Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10 MD and address of person who completed cause of death (Item 23a) (Type Print) 30. Nan Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) January 12, 2010 **Physician** 8:00 AM M Miles Thomas /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Anne Arundel 1906 Huguenot Place Severn Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Days Hours 1 € M 2 🗆 F 84 1925 19, Zuni, 118-14-8450 Sept Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Expandrent. In this natural once. 10d. Inside City Limits 10b. County 10c. City. Town or Location 10a. State 1√2 Yes 2 □ No Director Severn Anne Arundel 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21144 1906 Huguenot Place Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Yes 2 No If Yes, Give Year or Dates: WW 2 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2X No Specify. Specify: Black Completed by 3 ☑ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) US Postal Service 12 Clerk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Dorothy Parker William Miles ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Richmond, VA 123-02 Lullington Dr. (Son) Thomas Miles, Jr. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Calverton, New York 1/19/10 Calverton National Cem 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Cobb Funeral Home 21. Signature Funeral Service Licensee 98-08 Astoria Blvd. East Elmhurst, NY 11369 Approximate Interval Between Onset and Death 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Laws **Physician** di se or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated exerts. Examiner The law requires that the death certificate be executed physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 ☐ Other (specify) □Yes 2□No the Ö 9 Unknown signed by the ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 □ Yes 2 🗗 this certificate 1 ☐Yes 2 ☐No the Hospital or Attending Physician: 25. Was case referred to edical examiner? 26. Place of Death (Check only Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours alter com.

To the Funeral Director: After this of မ 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Mannes Death Certification: atural Division 5 Pending 1 ☐ Yes 2 ☐ No investigation Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29c. License number

State Registrar DHMH 17 Rev 1/2001

anic

Suite 128 Glen Burn trar's Signature

completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death January 10, 2010 **Physician** 1:20 Marion Mostyn AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Potomac Valley Nursing Home Rockville Montgomery | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day Year April 27) 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) 7 Year) 1917 **Funeral** Massachusetts 1 □ M 2 🗓 F 021-10-2570 92 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exercises. 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County 1X Yes 2 No Director Gaithersburg Marvland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20878 U.S.A. 11812 Longdraft Court Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🛛 No Specify: Specify: White \$ 3K Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Assistant Manager Bank 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Rebecca DeLaFuente Samuel Jacobs ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 11812 Longdraft Ct., Gaithersburg, MD 20878 Judith M. White 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 1/15/2010 Blue Hill Cemetery Braintree, MA 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22 Name and Address of Facility
Keohane Funeral Home 785 Hancock St., Quincey, MA 02170 Illlun 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Morria **Physician** 10 days /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, ed by the attending physician detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Day in the past 12 months? 1 □Yes 2 🗓 No Month Year Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 No 3 Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has perform 1 □ Yes 2 X No certificate Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 🖾 Nursing Home 5 🔲 Residence 6 🗆 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical and manner stated. within 2. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) eseavel BLUD Suite 330 2401 a 32. Registrar's Signature 31. Date filed (Month, Day, State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Physician/ JANUARY 3 Day 2010 ear 22:48 MAYES Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MONTGOMERY WASHINGTON ADVENTIST HOSPITAL TAKOMA PARK 8. Date of Birth If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** 4-29-1932 1 ☑ M 2 ☐ F Days Hours MARYLAND 577-40-6341 Director Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Director 1 Yes 2 No PRINCE GEORGE MITCHELLVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3902 KENCREST COURT 20721 U.S.A. within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11 Marital Status Armed Forces? Black, White, etc. ğ 1 Never Married 2 Married Maryland 21215-0036 BLACK 1 Yes 2 No Specify. If Yes, Give 3 XWidowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12th CONSTRUCTION PRIVATE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be a Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ewo and Mental is marked o ည GARLAND G. MAYES MARION HERBERT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CRYSTAL THOMAS/DAUGHTER 4405 WOODGATE WAY BOWIE, MD 20720 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State RIVERDALE CREMATORY 11-8-2010 RIVERDALE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility JB JENKINS FUNERAL HOME Signature of Funeral Savice Lig 15 7474 LANDOVERRD LANDOVER, MD 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying sician and burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last ate has been signed by the attending physician page 2 should be detached for use as the burial Physician/Medical Hospital or Attending Physiclan: The law requires that the death certificate be-IF FEMALE: f yes, outcome of pregnancy

Live Birth 2 Fetal death

Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ Month in the past 12 months? Day Yes 2 No 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 LNo 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed this certificate 1 Yes 2 No 1 Yes 2 10 No within 24 hours after death.

To the Funeral Director; After this certifica completed filled in by the funeral director, To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 TUNG 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28a. Date of injury 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending 1 🗌 Yes 2 🗀 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 2 [] Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0060100

Registrar

State

31. Date filed (Month, Day, Year)

31 University

SITUINSPUP

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** January 11, 2010 10:23 AM Danuta Mostwin /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 1300 Malvern Avenue Ruxton Birthplace (State or Foreign Country)
 Poland 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 08/31/1921 Months Days Min. Hours 1 □ M 2 X F 067-28-9281 88 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County Director 1 ☐ Yes 2 XNo Maryland Baltimore Ruxton 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1300 Malvern Avenue 21204 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2X If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify: Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Social Science +10 Writer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jozef Tadeusz Pietruszewski Irena Bronislawa 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6505 Darnall Road Baltimore, Maryland 21204 Jacek Mostwin - Son 20b. Place of Disposition (Name of cemetery crematory or other place)
Sacred Heart of Mary
01/18/2010 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, Maryland 4 Donation 5 DOther (Specify) Cemetery David J. Weber Funeral Homes P.A. 401 S. Chester Street Baltimore, 21. Signature of Funeral Service Lige Maryland 21231 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) isease ar Kinsons Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter the drifting Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Degeneration brain 24a. Was an autopsy performed? 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔼 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No

P.O. Box 68760 Records, A FUNDA

burial-transi and cate has been signed by the attending physician page 2 should be detached for use as the burial certificate After this death.

Funeral

Director

the

?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Wedical Evand in must be natified at

permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any Injury or other traumatic event, the Medical Examine must be one.

Physician /Medical

Examiner

Maryland 21215-0036

Baltimore,

Division of Vital Hospital or Attending

completely filled in by the funeral director, within 24 hours after deat To the Funeral Director: the ٥

> State Registrar

Medical

2 Accident

3 Suicide

29a. Certifier

4 Homicide

29b. Signature and title of certifier

29c. License number

1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

Delia Chiaramonte

28f. Location (Street and Number or Rural Route Number, City or Town, State)

6 ☐ Could not be

determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 2:57 A M 2010 Eyler Richard Mort January 12 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Hospice Dove House Westminster Carroll If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1**⊠** M 2□ F Yrs. Director 79 1930 Maryland <u>214-28-0812</u> Dec. 7. Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show r than "natural", or items 23a or 28a-f sho 1 ☐ Yes 2 XNo Director Maryland Carroll Keymar 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21757 703 Francis Scott Key Highway U.S.A. Funeral death 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 XYes 2 No
If Yes, Give
Year or Dates: 1955-61 filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ∐Yes 2 X No \$ Specify. 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) drywall/plaster contractor 12 construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be nent of Health and Mental Harrison W. Mort Nettie Ellen Eyler and N 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau Doris W. Mort/ wife Keymar, MD 21757 703 Francis Scott Key Hgwy. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Resthaven Mem. Gard. 1/15/2010 Frederick, MD 21. Sign of Joneral Service Licensee 22. Name and Address of Facility Hartzler Funeral Home (attarine) 6 E. Broadway Union Bridge, MD 21791 23a. Part1. Enter the disease, or complications that crused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on part line. Approximate Interval Between Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as Examiner **t191** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine ysician and e burial-transit death certificate be executed Box 68760, Due to (or as a consequence of): Physician/Medical attending physical for use as the l the IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) signed by the a o 1 ☐ Yes 2 ☐ No 9 Unknown The law requires that the 9 Unknown 23e. Did tobacco use contribute to the cause of death?" Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy 1 □Yes 2 No 1 ☐ Yes 2 **3** No the Hospital or Attending Physician: director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Other: 4 \square Nursing Home 5 \square Residence 6 \bigcirc Other (Specify) hospice 1 ☐ Yes 2 NO 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending death. 2 ☐ Accident investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: the 1 6 ☐ Could not be 3 ☐ Suicide in by t Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide filled 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated ical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check onl) one) 29b. Signatur d title of certifier 29d. Date signed (Month, Day, Year)

State Registrar 30. Name an

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

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address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 3:00 PM Malinowski 2010 Medical 4a. Facility Name (if not institution, County of Deat give street 4b. City **Examiner** Burnie Anne ington Tedica yen Center 5. Social Security Number 7. Age (In yrs. last birthday) If Under Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 □ M 2 🔀 F Months Days Hours Min. 03/11/1928 Mary Land 219-22-4277 81 Director Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 Yes 2 No Anne Arundel Co. Severn Maryland 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21144 United States 8157 New Cut Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Bace - American Indian. Armed Forces?,
1 Yes 2 A No Black, White, etc. þ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 72 hours after 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates 3 ¥ Widowed 4 ☐ Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker 9 yrs. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Margaret Szymanski Anthony Gnacyk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Timonium, Maryland 21093 Mrs. Darlene F. Becker/ Daughter 31 Wally Court 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 🖺 Burial 2 🗆 Cremation 3 🗆 Removal from State Holy Cross Cemetery 101/15/2010 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Singleton Funeral & Cremation 21. Signature of Funeral 22. Name and Address of Facility Services PA; 1 2nd Ave SW; Glen Burnie, MD 21061 M01121 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer nset and Death Immediate Cause (Final Priysician/ disease or condition resulting in death) Medical (or as a consequence of) Examiner heumonia Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury Examine Due to or as a consumence of Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical P.O. Box 68760 the attending ploched for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death 1 Yes 2 No cate has been signed by the page 2 should be detached Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð rena Records, 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has I completed filled in by the funeral director, page 2 s autopsy 2 🗌 No 1 Yes 1 Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 2 XNo Other: မ 1 Tyes 1 Unpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title 29d. Date signed (Month, Day, Year)

State Registrar Name and address of

Vadim

rive, Glen

Burnie

person who completed cause of death (Item 23a) (Type, Print)

ar's Signature

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 00662 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 10^{ay} Physician/ Month 01 Year 10 Harold Thaver Meryman Medical 0155 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery General Hospital 01ney Montgomery 8. Date of Birth (Month, Day, Year) 2/5/1921 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) If Under 24 Hrs. Funeral 6. Sex 9. Birthplace (State or Foreign 1 M 2 D F Months Days Hours Min Country) **Director** 001-14-7077 88 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery Ashton 1 Yes 2 KNo 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? the Medical Examiner must be Funeral items 23a 1600 Tucker Lane 20861 United States within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. ō ģ 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: "natural", Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) MD Medicine Research Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fili Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve ပ Richard Sumner Meryman <u>Charlotte Bates</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) N. Washington St. Suite # 240 Rockville MD 20850 Camilla O. McRory- Attorney 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 1/13/2010 Beltsville MD 21. Signature of Funeral Service Lice 22. Name and Address of Facility 933 Gist Ave. Silver Spring MD Rapp Funeral & Cremation Ser. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ 100 THS Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions Examine cause. Enter Underlying Cause (Disease or linjury that initiated events Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Dav Year Pregnant at time of death been signed by the should be detached Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 hknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has completed filled in by the funeral director, page 2 autopsy performed Yes 2 2 1 Yes 2 4No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No Hospital: 2 1 Inpatient 2 NER/Outpatient 3 I DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural iniury 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 24 hours after dear Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the only one 29d. Date signed (Month, Day, Year)

State Registrar 10301

31. Date filed (Month, Day, Year)

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year 3:55 AM MCKINNEY 2010 GLADYS Μ. 11 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) BALTIMORE BALTIMORE FUTURECARE NORTH POINT If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 0 7 / 25 / 1918 5. Social Security Number 7. Age (In yrs. last birthday) Days Hours Min Months TENNESSEE 91 408-32-0891 Usual Residence of Decedent 10d. Inside City Limits 10h County 10c. City, Town or Location 10a State 1X Yes 2 □ No N/A BALTIMORE 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 21224 U.S.A. CLINTON STREET 503 S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1∐Yes 2∭Mo Specify: Specify: WHITE 3 Widowed 4 N Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) MANUFACTURING LABORER 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) **BERTHA** COMBS MACKLEY **JOHN** HENRY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) PATSY CRUNKILTON/DAUGHTER CLINTON STREET, BALTIMORE, MD 21224 503 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State BALTIMORE, MARYLAND BAYVIEW CREMATORY 1/12/10 4 ☐ Donation 5 ☐ Other (Specify) ²², Name and Address of Facility LILLY & ZEILER INC. FUNERAL HOME 1901 EASTERN AVENUE, BALTIMORE, MD 21. Signature of Funeral Service Licensee and the 21231 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cardionword disease or condition resulting in death) uence of): Due to (or as a conse Mulhlor Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Directo for as a consequence unal Acuts Due to (or as a consequence disease anemia If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month Day 5 Other (specify) 9 | Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ triknown 24a. Was an Were autopsy findings available prior to completion of cause of autopsy performed' 2 🗆 No 2 🗔 1 ☐ Yes

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

28a-f show

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Items 23a

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permit. Pages 1 and 2 to Department of Health at Important: If item 27 is any Injury or other trau

72 hours after

Baltimore, Maryland 21215-0036

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Box 68760,

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Division of Vital Records,

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Director

Funeral

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traumatic event, the Medical Examiner must be notified at

Examiner attending physician and for use as the burial-transit Physician/Medical ed by the a à Completed certificate has funeral director, Be this Certification: To After t al or Attendi after death. | Director: / filled in by the

IF FEMALE 23b. Was decedent pregnant in the past 12 months? 9 Unknown

25. Was case referred to medical examiner?

1 | Yes 2 | 1√10

27. Manner of Death

2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only

1 Natural

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 Inpatient 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State)

6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

and manner stated.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier M.D.

5 Pending

29c. License number D69540 29d. Date signed (Month, Day, Year) 2010.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Parkville MD 21234. Swite 204 Waltham words 8813 31. Date filed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

To the Hospital within 24 hours a To the Funeral C completely filled

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	For State Registrar		State	of Ma	rylanc		irtment of H tificate of L			ental Hy	_	2111	0	00564
1. Decedent's Name (First, Middle, Last)									imodio or E	Joann	Reg. No.				3. Time of Death	
Physician/ Medical Doris Pender Moon										Month Day 01/12/2010					2:42 A M	
Examiner 4a. Facility Name (if not institution, give street and number)								4b. City, Town, or	r Location	of Death			c. County of D	eath		
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Fune			5. Social Security Numb		6. Sex 1 ☐ M 2 ☑ F			st birthday) Yrs.	If Under 1 Year Months Days	If Unde Hours	Min.	8. Date of Bir (Month, Da	v Year)		Birthpl Count	lace (State or Foreign ry)
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Z13-0036 in 72 hours after e. nan "natural", o		d by	3 ☑ Widowed 4 □		If Yes, G		lo	1	☐ Yes 2 🗹 No			Specify: White				
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of Her fitem			20a. Method of Disposi				20b. Pla	ace of Dispos	sition (Name of latory or other place			ate		ocation - City	or Tov	vn, State
Page Page ment lant lant lury or			1 Donation 5			m State			e Cremato	· ·	1/14/	2010	Be.	ltsvill	Le,	MD
Baitimore, Maryland 21213-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at	once,		21. Signature of Funera	Service V	censee	MOO	382		Name and Address		,	ation	Ser			st Ave. Spring MD
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 8 State of Maryland Department of Health and Mental Hygiene Per fh, g913,03/02/2011dhb Certificate of Death 1 - For State Registrar Reg. No 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) McGhee Month **Physician** zabeth Ann 3:00 2010 anuaru /Medical 4b. City, Town, or Location of Death

4000 Frank (n. 40)

17 mov 6,

If Under 1 Year If Under 24 Hrs. County of Death 4a. Facility Name (If not institution, give street and number 4c. Examiner 1+05P1 Saltimore ranklin b Quare Md. 21237 5. Social Security Number 212-422-2 8. Date of Birth (Month, Day, Year) 07/31/1943 Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Months 1 M 2 F 66 MD Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State 28a-f show Examiner must be notified at Baltimore MD 1 ☐Yes 2F No Middle River Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ŏ 607 Sopwith Drive 21220 23a USA death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: items 2 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2 ☐ No Specify: <u>م</u> Specify: White 3 Widowed 4 Divorced Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", any Injury or other traumatic event, the Medical Exa Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 th and Mental Hygiene. 7 is marked other than "n Insurance Elementary/Secondary (0-12) College (1-4or 5+) Clerical 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Samuel Rogers Armeda Riffle ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert McGhee / son 2923 Delaware Avenue Balto. MD 21227 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 Burial 2 Cremation 3 Removal from State Holly Hill Cemetry 1/15/10 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 300 Mace Ave. Balto. MD ture of Euheral Service Licensee a Connelly Funeral Home of Essex 21221 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on ach line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-transi and Due to (or as a consequence of) physician at the burial certificate be Physician/Medical attending p for use as as IF FEMALE: nse 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 🗆 Ectopic pregnancy Month Year signed by the a 5 Other (specify) P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown been si Completed Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s has autopsy performed death? certificate 1 ☐Yes 2 ☐No 1 □Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide TSC Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medican Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signatu

DHMH 17 Rev 1/2001

State Registrar 30. Name and

31. Date filed (Month, Day, Year)

Somlec

Square Dr. Biltmore, MIS 21237

ess of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
126 Per Verb (3899) 1/14/2010 III.
State of Maryland / Department of Health and Mental Hygiene for State Registrar Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Day Hazel Julia Motes 8:34 Am 2010 Januar Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1504 Upshire Road #2D N/A Baltimore 5. Social Security Numbe If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 216-42-7991 1 M 2 XF Months Davs Hours Country) Marvland **Director** 65 Aug.6 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at Director MD N/A Baltimore 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3505 Frankford Avenue 21214 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian Armed Forces Black, White, etc. þ 1 Never Married 2 Married Yes 2X No Baltimore, Maryland 21215-0036 hours after 1 ☐ Yes 2XXNo Specify: If Yes, Give Specify: Black "natural", 3 Divorced 4 Divorced Completed Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 72 marked other than 1 1th Grade College (1-4 or 5+) Private Duty Nurse State of Maryland Be 1 and 2 should be filed f Health and Mental Hy item 27 is marked ott 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Washington Conway Martha A. Doswell 19a. Informant's Name/Relationship (Type, Print) Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard L. Motes, Sr. 3505 Frankford Avenue Baltimore, MD 21214 item 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot Page 1 1 Burial 2 Cremation 3 Removal from State 4 Donation 5X Other (Specify) Entombment 1/13/10 Pikesville, MD Druid Ridge Cem 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Chatman-Harris Funeral Home 4210 Belair Road Baltimore, 21206 MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final (Physician) east Cancer disease or condition resulting in death) INS Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Exami that the death certificate be executed and that initiated events Due to (or as a consequence of) resulting in death) Last burialattending physician for use as the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Pregnant at time of death 9 Unknown Division of Vital Records, P.O. ģ Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe certificate 2 No 1 Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) daughter's examiner? Other: 4 Nursing Home 1 Tyes 2 No Residence 6 XX ther (Specify) residence 2 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28b. Time of 28a. Date of injury 28c. Injury at Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director; After completed filled in by the funer (Month, Day, Year) 1 Natural 5 Pending work' 1 ☐ Yes 2 ☐ No M Accident Investigation Suicide 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical

State Registrar 29a. Certifier (Check

only one)

3 🗀

JAN 1 4 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HARVEI

CAN

32. Registrar's Signature

29b. Signature and title of certifier

MORA

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6701

1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

Charles

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Si

NowWON

29d. Date signed (Month, Day, Year)

2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TITEM/30 per DVR, G899, In 14/2010, WS Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 1, Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Theodore Walter Majka 20ÎÖ January 12:30 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 7683 Blueberry Hill Lane Ellicott City Howard 5. Social Security Numbe If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 Wew York 8. Date of Birth **Funeral** 1 X M 2 - F Days Hours April 20, 1943 Director 069-34-4800 66 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he notified an once. or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Howard Ellicott City 1 🗆 Yes 2 🏝 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21043 U.S.A. 7683 Blueberry Hill Lane 12. Was Decedent Ever in U.S. 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 Widowed 4 A Divorced Specify: Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) IT Management Finance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Walter Majka Janina Anusiak 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth Krahel (Girlfriend) Ellicott City, Maryland 21043 7683 Blueberry Hill Lane 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State Atlantic Crematory 4 Donation 5 Other (Specify) 1-9-2010 Glen Burnie, Maryland of Funeral Service Licer Signatura 22 Name and Address of Facility Witzke Funeral Homes, 5555 Twin Knolls Koad Inc. Columbia, Maryland 21045 23a Part 1. Enter the disease. , or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Onderlying Cause (Disease or iinjury Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Dav 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probabiy 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) eral Director: After thi filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural iniury 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation M Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical 1 Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Continue Nurse Practionar To the basis of my knowledge death contend at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I 29b. Signature and title of certifie 006640 and address of person who completed cause of death (Item 23a) (Type, Print) W University Of MD Med. System Baltimore, MD 21201 State Registrar

DHMH 17 Rev 7/2009

10-00201 George Robert i	/laul	Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. er State of Maryland / Department of Health and Mental Hygiene	00668										
		1- For State Certificate of Death Registrar 2010											
Physicia Medical Exami	-	Month Day Year OF	ne of Death 25 hrs										
Wedical Exami	Hei	GEORGE ROBERT MAULER, JR. January 8, 2010 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death											
		1203 Meadow View Road Pasadena Anne Arundel											
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 M 2 F 59 Yrs. 7. Age (In yrs. last birthday) Yrs. 1 If Under 1 Year If Under 24Hrs. Months Days Hours Min. 01/01/1951 01/01/1951	(State or ryland										
any		Usual Residence of Decedent	nside City Limits										
*		1	Yes 2 No										
ne Maryland or 28a-f show fied at once.	Director	MD Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?											
the Mi a or 2:	ä	1203 Meadow View Road 21122 U.S.A.											
1 with ms 23.	era	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-	lian, Black,										
r death	Funeral	Never Married 2 Married 1 Yes 2 No											
is afte ural",	ĝ.	3 Widowed 4 Divorced If Yes, Give Year 1972-76 1 Yes 2 No specify: Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry											
72 hou	ete	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DO NOT use retired)											
036 vithin ene.	Completed	9 Plumber General Mot	ors										
15-0 filled v I Hygi ed other		17. Father's Name (First, Middle, Last) George Robert Mauler, Sr. 18. Mother's Name (First, Middle, Maiden Surname) Helen Vivian Reightle	20										
212 uld be Menta marke	o Be	George Robert Mauler, Sr. Helen Vivian Reightle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Co											
MD 2 sho		James Mauler / Brother 113 Carroll Road, Pasadena, MD 2112											
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Bygene. Interfer I friem 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once.	Ī	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Something or Company or	State										
imo Pages nento ant: l		4 Donation, 5 Other Specify: MD Veteran Cem. 01/13/10 Crownsville	e, MD										
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health in and Mental Hygiens in the Maryland Important: If item 77 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Survice Licensee 22. Name and Address of Facility G. J. Gonce Funeral Ho	me, PA 21122										
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Appr	roximate Interval										
Medical		failure. List only one cause on each line. Immediate Cause (Final disease a. Hanging	ween Onset and Death										
Examiner		or condition resulting in death) Due to (or as a consequence of):											
	<u>je</u>	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):											
- 110.	Examiner	(Disease or injury that initiated events resulting in death) Last Use to (or as a consequence or):											
ecuted and reasit		d	_										
Ox 68760, sath certificate be ex attending physician or use as the burial.	sician/Medica	UNPENDED AMENDED											
Box 68760, a death certificate be the attending physic of for use as the bur	Ž	F FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 2 Fetal death 3 Ectopic pregnancy 23d. Date of delivery Month Day	Year										
OX 6 ath cer attendi	Sici	4 Pregnant at time of death 5 Other (Specify)											
5.0. Boy that the death	Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cau	use of death?										
P.C es that igned	Ď	1 Yes 2 ✓ No 3 Probably 4	4 Unknown										
rds, requir been s	lete	24a. Was an 24b. Were autopsy fi autopsy prior to completi											
of Vital Records, P.O. ing Physician: The law requires that the After this certificate has been signed by uneral director, page 2 should be detach	Completed	performed? death? 1 Yes 2 ✓ No 1 Yes	2 No										
al R ian: T sertific ctor, p	BeC	25. Was case referred to medical examiner?											
F Vit Physic r this o	70	1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 V Other Scene	9										
Division of Vital Records, P.O Ital or Attending Physician: The law requires that the star fare death and Director: After this certificate has been signed by led in by the funeral director, page 2 should be detacted.	<u>:</u>	1 Natural 5 Pending FOUND: 1 Yes 2 ✓ No Subject hanged himself											
IVISIOI or Atten of the death Director:	ficat	2 Accident Investigation Jan 8, 2010 US00 hrs 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Rou	ite Number, City										
Divisior Hospital or Attend 24 hours after death Funeral Director:	Certification:	3 Suicide 6 Could not be determined (Specify) Stairwell outside or Town, State) 1203 Meadow View Road, Pasadena, MD)										
Division of Vital Records, P.O. Box 68760, within 24 hours after death certificate be exect within 24 hours after death are free that the fraint after death completely filled in by the funeral director. After this certificate has been signed by the attending physician an completely filled in by the funeral director, page 2 should be detached for use as the burial - to		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s).	e(s)										
To the within. To the comple	Medical	29b. Signature and title of certifier 29d. Date signed (Month, Da)											

10

Donna M. Vincenti, MD Assistant Medical Examiner 31. Date filed (Month, Day, Year) ----State Registrar

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a)

- Imo

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

January 8, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Myrtle I. Mattis **Physician** 20:43 PM January 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner TMOK Ba 5 8. Date of Birth (Month, Day, Sep. 4, If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Númber 212-34-2552 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Months Min 1937 Mary land 1 □ M 2 🕅 F 72 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State ed other than "natural", or items 23a or 28a-f show event, the Medical Evanther must be nutified at Glen Burnie MD Anne Arundel 1 ☐ Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21061 United States 100 Gilmore Street Funeral . Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian Black, White, etc. 1 Never Married 2 Married White Maryland 21215-0036 1 ☐ Yes 2 🕍 No Specify à 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Myrtle Lewis Charles Jenkins ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 100 Gilmore St., Glen Burnie, MD 21061 19a. Informant's Name/Relationship (Type. Print) Charles Mattis - Husband Baltimore, 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) Method of Disposition T⊠Burial 2 ☐ Cremation 3 ☐ Removal from State Western Cemetery 1-13-2010 Baltimore, Maryland Q ☐ Other (Specify) 4 Donation Ambrose Funeral Home, Inc. Name and Address of Facility 2719 Hammonds Fry Rd., Lansdowne, MD 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Myocard 30 minutePhysician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner nsion Due to (or as a consequence of) 68760. Physician/Medical requires that the death certificate as Box 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy for 1 5 ☐ Other (specify) 1 ☐ Yes 2 DNo o detached 9 Unknown 9 Unknown ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed certificate 1 □Yes 2 No 1 ☐ Yes 2 ☐ No Vital Physician: funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 ₩No 1 Impatient 2 ER/Outpatient 3 DOA Certification: To oţ this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Division Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide e Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical соmpletely and manner stated. within 2. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Month, Day, Year)

AGNES HOSPITAL, BALTIMORE, MD

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND ITEM#19b, perINF, 6899, 1720/2010, WS

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Alden C. Manchester January 2010 1:44 P. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Montgomery Suburban Hospital Bethesda Social Security Number 8. Date of Birth (Month, Day Year) December 6,1922 If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Hours Min. 267-20-8348 1 TM 2 | F 87 Connecticut Director Usual Residence of Decedent shov 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland | Montgomery Bethesda 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 6609 Pyle Road 20817 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces' Black, White, etc. 1 Never Married 2 Married X Yes 2 No Baltimore, Maryland 21215-0036 $_{ ext{Spec} \textit{ify}}: ext{White}$ 1 ☐ Yes 2 X No Specify: If Yes, Give 3 Divorced 4 Divorced Year or Dates. WWII 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) U.S. Department of Elementary/Seconday (0-12) College (1-4 or 5+) Economist Agriculture Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Allen W. Manchester Marie Loveness 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 20832 Sharon Hawkins/Daughter 18072 Rolling Meadow Way, Olney, Maryland 20872 20b. Place of Disposition (Name of cemetery, crematory or other place)
Montgomery
Crematorium, Inc. 20a. Method of Disposition 20c. Location - City or Town, State Janua 🗝 14, 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2010 Bethesda, Maryland 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase. Inc. 7557 Wisconsin Avenue Bethesda, Maryland 20814 21. Signature of Euneral Service Jie M01498 23a. Part 1. Ent. the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final and Death Henorhan Physician/ a Gastroin testing Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any Lading immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner Due to lor as a consequence of Due to (or as a consequence of): Physician/Medical or Attending Physician: The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year ☐ Pregnant at time of death ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Record 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perforn 2X 1 ☐ Yes 2 ☐ No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျ 1 Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at work? 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28d. Describe how injury occurred 1 Alatural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a Medical Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature apa 29d. Date signed (Month, Dav. Year) 0065723 MADER MD 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8600 Old Georgetown Road, Bethesda, Maryland 20814 Amirali Nader, M.D. 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

25

Amend #8 per FH g899 1/15/10 TT State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death **Physician** Day Year 230 A M SSC 01 /Medical 2010 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death P9 reclesic de 6/15/1921 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, **Funeral** Months Days Hours Min. Director 88 Pennsylvania Usual Residence of Decedent 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits r than "natural", or items 23a or 28a-f shov the Medical Examinar is ust be notified at Director 1 ☐ Yes 2 X No Maryland Frederick Keymar 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 12022 Legore Bridge Rd. Funeral 21757 hours after death U.S.A 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify Completed by 3 Widowed 4 Divorced Specify White 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 72 P Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nati any injury or other traumatic event, the Medica 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) stone, sand, gravel Elementary/Secondary (0-12) College (1-4or 5+) product transportation truck driver 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) မ Napoleon Naugle Emma Turner 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carolyn R. Naugle/ wife 12022 Legore Bridge Rd. Keymar, MD 21757 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 St Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Mt. Hope Cemetery 1/13/2010 Woodsboro, MD 22. Name and Address of Facility Hartzler Funeral Home 21. Signature of Fune al Service Licenses athanine (404 S. Main St. Woodsboro, MD 21798 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** LZhiemer /Medical ue to (or as a consequence of): **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year signed by the a d be detached for 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? has 24a. Was an certificate 2 PNo 1 ☐ Yes 2 🗆 No 1 Tyes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 Yes 2√No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending after death 2 Accident investigation 1 ☐ Yes ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide thin 24 hours aft the Funeral Di mpletely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D664 Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signatur State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ JANUARY 12, 2010 IRMA EDITH NAY 9:50 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death FOREST HILL HEALTH & REHAB CENTER FOREST HILL HARFORD 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign **Funeral** Days 1 □ M 2 🛣 Months Hours Min. Year! Director 041-28-1198 81 Germany Usual Residence of Decedent 28a-f show 10b. County 10c. City. Town or Location with the Maryland the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 XNo <u>Marylan</u>d Harford Forest Hill 10e. Street and Number ō 10f, Zip Code 10g. Citizen of What Country? 23a Funeral 2531 Sandy Hook Road 21050 USA filed within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, "natural", or Completed by 1 Never Married 2 Married ☐ Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: 3 ₩ Widowed 4 □ Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) nd Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 12 Nurses Aide Healthcare Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) if Health and Mental ည Page 1 and 2 should be Richard (unk) Ruhm Ottilie (unk) Schultz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gina A. Isom / Daughter 2531 Sandy Hook Road, Forest Hill, MD 21050 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 a
Department of I
Important: If ite
any injury or ot
once. cemetery, crematory or other place) 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp: 1-14-10 Towson, Maryland Signature of Funeral Service License 22. Name and Address of Facility McComas Funeral Home, 1317 Cokesbury Road, , P.A. <u>Abing</u>don, MD 21009 athless lel 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ 0 0 M disease or condition 1 em Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): -transit Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Be Completed by Physician/Medical or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Pregnant at time of death Day Year ed by the a 9 Unknown ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. certificate has been signed I rector, page 2 should be det 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed Yes 2 N 2 🗌 No Division of Vital funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) 2 1 🗌 Yes 2 10 Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending 1 ☐ Yes 2 ☐ No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Hospital 24 hours a Funeral I Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 hou To the Fune completed file 29a. Certifier 2 Medical Examiner: Dn the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 581

State Registrar ROBERT DUNCAN

JAN 1 5 2010

DHMH 17 Rev 7/2009

BEL AIR, MD.

21014

615 WEST MACPHAIL ROAD

32. Registra s Signa

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 00673 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year 2229 M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign Country) unk 7. Age (In vrs. last birthday) Funeral 1 Ø M 2 □ F Months Days April 8 68 Director 170-3**4-**9674 Yrs Usual Residence of Decedent 28a-f show within 72 hours after death with the Maryland Director 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified 1 Yes 2 XNo Maryland Prince Georges Bowie 5 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? 23a Funeral 6610 Crain Highway 20716 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 0 ò 1 Never Married 2 Married 1 Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify. Specify: "natural" Completed 3 Widowed 4 Divorced White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) U.S. Government unk Contractor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I ဂ္ bef unk unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1212 Abington Road, Clarks Summit, Pennsylvania 1841 item 27 Joseph O'Brien/ Attorney 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Page 1 5 ☐ Burial 2 Cremation 3 ☐ Removal from State January Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland Metro Crematory, Inc. 2010 22. Name and Address of Facility Cremation Society of Maryland, 21. Signature of Funeral Service License Amanda Heaston 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final on Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical that the death certificate be 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ LUNG Division of Vital Records, Hospital or Attending Physician; The law requires Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Hospital Other: Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer. Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, ceatin occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier Name and address of person who completed cause of dath (Item 23a) (Type, Print) DEKENSEHIGHWAGANNAPOLII MOZIYOI MICHAEL VENTAM 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Sally J. Neighly January Medical 2010 5:55 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery General Hospital Olney Montgomery Social Security Number 6. Sex If Under 1 Year 7. Age (In vrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Country) OW York Days Hours Min. 1 □ M 2 🗓 F Months 217-34-1274 Director New June 1937 Usual Residence of Decede 28a-f shov 10b. County within 72 hours after death with the Maryland or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Montgomery Demascus 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 25112 Angela Court 20872 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates White 3 Wildowed 4 Divorced Specify: Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working should be filed within 72 and Mental Hygiene. life. DO NOT use retired) United States Elementary/Seconday (0-12) College (1-4 or 5+) 12th Clerk Postal Service traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. John Charles Luther Agnes Clare Withers 19a. Informant's Name/Relationship (Type, Print) Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Merle Edwin Neighly, Jr./ 25112 Angela Court, Demascus, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) West Arundel 1/13/2010 Odenton. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Donaldson Funeral Home, M01103 313 Talbott Avenue, Laurel, MD 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events and -tra Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month is certificate has been signed by the director, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖺 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 Tyes ☐ Yes 2 - No 25. Was case referred to medical 26. Place of Death (Check only one) Be 2 1 No decline Other: 1 Yes ၉ 1 Inpatient 2 TR/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral di 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes 2 🗌 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier Med Sincel 0050410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 18101

Registrar

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** 225 MARGARET dan 2010 /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner - canten Baltimore tuture care 9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, Date of Birth (Month, Day, Year) **Funeral** Days 212-36-339 1□M 2□A Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural"; or items 23a or 28a-f show any liquy or other traumatic event, the incident Examine must be mutified any once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 □ Yes 2 □ No MD Director n/a Baltimore 10e. Straet and Number 10f. Zip Code 10g. Citizen of What Country? 21230 45 East Randall Street U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 💆 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc 1 Never Married 2 Married If Yes, Give Year or Dates: Specify: White 1 ☐Yes 2 XNo 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Jones Eleanor Reiley ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 45 East Randall Street Baltimore, Maryland 21230 Andrew H. Niroda husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State Brooklyn Park, Maryland Cedar Hill Cemetery Jan 16, 2010 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Polyniak Funeral Home P.A. 21. Signature of Funeral Service Licenses 130 E. Fort Avenue Baltimore, Maryland 21230 Approximate nterval Between nset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. ROIOVAJCA Immediate Cause (Final **Physician** 1 disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine use as the burial-trai Due to (or as a consequence of) After this certificate has been signed by the attending physician funeral director, page 2 should be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 1 ☐ Yes 2 ☐ Wo 5 ☐ Other (specify) 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Jnknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy perform 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 **1** No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Math 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation (Month, Day, Year) 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

P.O. Box 68760.

Baltimore, Maryland 21215-0036

The law requires that the death certificate be executed Division of Vital Records, the Hospital or Attending Physician: within 24 hours after death

To the Funeral Director:,
completely filled in by the f

29a. Certifier (Check only Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of ertifier 29d. Date signed (Month, Day, Year) 29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) JAN 14 2010

32 Registrar's Signature

State

Registra

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. / 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Nellie Ann O'Neil January 15 par. Physician 6:08A /Medical 4b. City. Town, or Location of Death Facility Name (If not institution, give street and number) Examiner 8. Date of Birth (Month, Day, **Funeral** 2**℃** F Hours Country) Virginia 13, 1941 Mar Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a, State 28a-f show ed other than "natural", or items 23a or 28a-f show event, the Medical Evanings must be notified at MD Anne Arundel Severn 1 TYPS 2 TINO Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21144 U.S.A. 8122 Pasture Court Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 M No Specify: White Specify: by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Grocery Stone Floral Designer 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be is marked Charles Porter Flippin Viola Grace Jack ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Thomas S. O'Neil/Husband 3122 Pasture Court, Severn, Maryland 21144 Department of Health Important: If Item 27 Injury or other 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 20a. Method of Disposition Glen Haven Mem. Park Jan 18,2010 Glen Burnie, Maryland 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Singleton Funeral & Cremation 21. Signature of Funeral Service Licensee M01580 Services PA 1 2nd Ave, SW Glen Burnie, MD 21061 tolle 23a. art1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final OBSTRUCTIVE LUNG DISCHSU Physician CULONIC disease or condition resulting in death) /Medical Examiner THROWS OCH PORNIN Se mentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examine Due to (or as a consequence oi): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day Month 4 Pregnant at time of death 5 Other (specify) ☐Yes 2 ☑No has been signed by the e 2 should be detached g T Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 2 🗖 No 2 DNo 1 □Yes 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Impatient Certification: To 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Alatural М 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deatl

To the Funeral Director:
completely filled in by the 6 ☐ Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29b. Signature and title of certifier 29c. License number January 13, 2010. 00 55703 comp eted caus of death (Item 23a) (Type, Print) 30. Name and address of persoft wire cover son Buloran moint ASUINON Barnson 31. Date filed (Month, Day, State

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician/ Oxendine. 5100 am Ta mes Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore 4113 Eastmont Avenue g. Birthplace (State or Foreign Country)
Maryland 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Days 1 🛣 M 2 🗆 F 0492671957 **Director** 52 216-68-2709 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Director 1 XYes 2 ☐ No MD Baltimore N/A10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 4113 Eastmont Avenue 21213 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11 Marital Status Black, White, etc. þ 1 Never Married 2 X Married 1 ☐ Yes If Yes, Give 2 No Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify: Completed 3 Widowed 4 Divorced Black Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Texico Builders Home Improvement 12th Grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Josie Taylor James <u>Oxendine Sr</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4113 Eastmont Ave., Balto., MD 21213 <u>Terha Jett Oendine(Wife)</u> Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of King Memorial Park Cemetery 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 01/16/10 Baltimore, MD ^{22, Name and Address of Facility}
Joseph H. Brown Jr. Funeral Home
2140 N. Fulton Ave., Baltimore, MD 21. Signature of Euneral Service Licensee iam 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ma cancer Physician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine Due to (or es e nonsequents) of): cause. Enter Underlying Cause (Disease or iinjury attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Division of Vital Records, P.O. Box 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Month Year Day Pregnant at time of death i signed by the a 2 🗌 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available 24a. Was an autopsy performed Yes 2 4 prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify, 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this of completed filled in by the funeral direction. AMES 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: To the Hospital or Attending I within 24 hours after death. (Month, Day, Year) Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier . Cartifying Nurse Practioner: To the best of my knowledge, death ontuin diet the time, date and class, and dus to the courses and 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 110064267

State Registrar

DHMH 17 Rev 7/2009

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827 lenden Au Balt MO 21201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 1-1010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Birthplace (State or Foreign Country) **Funeral** Months Days 1 № M 2 🗆 F MISSISSIDDI Director death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show traumatic event, the Medical Examiner must be notified at 1 s 2 No Director 10g. Citizen of What Country? 10e. Street and Number ò 23a Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) items ? Race - American Indian, Black, White, etc. . Was Decedent Ever in U.S. Armed Forces? 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married Married Baltimore, Maryland 21215-0036 ò 1 □Yes No Specify. 2 3 Widowed 4 Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+ Health and Mental Hygiene. Elementary/Secondary (0-12) Mother's Name (First, Middle, Maiden Surname 18. 17. Father's Name (First, Middle, Last) Be ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Pt 110 MD 212 injury or other Department of Heal Important: If Item 2 any injury or other once. 20b. Place of Disposition cemetery, cremator 20a. Method of Disposition Pages 1 Burial 2 Cremation 3 R 3 Removal from State Ser 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** enentic /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin, Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Hospital or Attending Physician; The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? Pregnant at time of death 5 Other (specify) 1 □Yes 2 □ No cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 Probably 4 Unknown 1 🗌 Yes 2 🗌 No Completed DM 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe within 24 hours after death.

To the Funeral Director; After this certificate I completely filled in by the funeral director, page. HIN 2□No 1 ☐ Yes 2 MNo 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 11110 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

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Baltimore MD

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32. Registrar's Signature

Year)

31. Date filed (Month, Day, Ye

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Dav Year 08 AM BENEDICT JANUAL Medical OV 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death BAYVIEW Medica HOPKINS Himont If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Mary Land 7. Age (In yrs. last birthday **Funeral** 8. Date of Birth 1 🟋 M 2 🗆 F Days Months 70 December 27,1939 217-34-3773 Director Usual Residence of Decedent 28a-f shov 10a. State 10c. City, Town or Location ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10d. Inside City Limits Director Maryland Baltimore Dundalk 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21222 USA 7827 St. Bridget Lane permit. Page 1 and 2 should be filed within 72 hours after death v. Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items, any injury or other traumatic event than "natural". Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 X Married ģ. Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: Yes. Give 3 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 8 years Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Charles Pusinsky Concetta Vinci 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Lois Pusinsky wife 7827 St. Bridget Lane, Dundalk, Maryland 21222 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State January 15, 1 🔀 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) cemetery, crematory or other place) Holy Cross Cemetery Glen Burnie, MD. 2010 21 Signature of Funeral Service Licensee ²²Connelly Funeral Home Of Dundlak, P.A. 7110 Sollers Point Road, Dundalk, Md. 23a. Part 1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Estonly one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death ASCUD Physician/ Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): the attending physician and hed for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death signed by the a 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown P.O. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown certificate has been si rector, page 2 should I 24a, Was an 24b. Were autopsy findings available autopsy performed 2 No 1 Yes 25. Was case referred to medical examiner?

1 X Yes 2 No funeral director, Be 26. Place of Death (Check only one) Hospital Other: ၉ 1 Inpatient 2 K ER/Outpatient 3 I DOA within 24 hours after death.

To the Funeral Director: After this of completed filled in by the funeral dir 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury 1 Natural work? 5 Pending Division Accident 2 Accider
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 2. Registrar's Signa State

DHMH 17 FeV 7/2009

Registrar

JAN 15 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** POTIS ETTA 10 10 ŧ /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince han-el George 5 Regional highital aurel If Under 24 Hrs. If Under 1 Year 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M 2 1 F 02/28/1929 80 Director 244-40-9288 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, I'm Midfoll Evans in a trust by myllfold at 1XYes 2 No Director NONE Washington DC 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1358 Fairmont St. NW #2 20009 14 Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 72 hours after 1 ∐Yes 2 ⊠ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 Specify: Black 1 ∐Yes 21 No Specify. 2 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) filed within 7 I Hygiene. other than "n Elementary/Secondary (0-12) College (1-4or 5+) Housekeeper Domestic 12 should be filed wi h and Mental Hygier 7 is marked other th 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ Callie Hall Ella Wall 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1 and 2 s Health ar 1358 Fairmont St. NW #2 Washington DC 20009 permit. Pages 1 and Department of Health Important: If Item 27 any Injury or other tr William C. Thomas 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition MCXBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sunset Mem. Gar. Cem. 01/20/2010 | Charlotte, NC 22. Name and Address of Facility Marshall's Funeral Home 21. Signature of Funeral Service Licensee 4217 9th St NW Washington DC 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Supric Shoule. disease or condition resulting in death) /Medical Examiner Due to (or as a nsequence of): siz gazerli Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): be executed burial-transit (E. coli 人て 1 and Due to (or as a consequence of): attending physician for use as the buria Box 68760. Physician/Medical ARF. IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 1 □ Yes 2 □ No 5 Other (specify) ned by the a P.0. 9 Unknown 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 9 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown si Elmation Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐Yes 2 ☐ No this certificate 1 ☐ Yes 2 No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1☐ Yes 2☐No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending Pl 24 hours after death. Funeral Director: After t 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 24 hours a 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated To the I within 2. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2010 D68782 January 10, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD.

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 00682 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ JANUARY 2010 3:35 P^M HARRIET ELAIRA Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** FREDERICK FREDERICK FREDERICK MEMORIAL HOSPITAL If Under 1 Year If Under 24 Hrs. g. Birthplace (State or Foreign 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Hours Country) MD. 1 □ M 2 🗹 F Min. 217-30-6488 Director Usual Residence of Decedent ıral", or items 23a or 28a-f show I Examiner must be notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location with the Maryland Director FREDERICK MD. FREDERICK 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21701 SOUTH USA Funeral WEST 211 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Yes 2 No Completed by Never Married 2 Married Maryland 21215-0036 Specify: BLACK 1 ☐ Yes 2. No Specify: "natural", 3
Widowed 4 Divorced Year or Dates. or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) 2 1 R S J. S. GOV. Elementary/Seconday (0-12) DIRECTOR SERV. should be filed with h and Mental Hygien 7 is marked other ti Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) PALMER HARRIETT Z. SUMMERS ပ္ CHARLES 19a. Informant's Name/Relationship (Type, Print)
RODNEY PACMER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (SON) SOUTH ST FREDERICK MD 21701 RODNEY 211 WEST 1 and 2 s of Health item 27 Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition permit. Page 1 s
Department of IImportant; If ite
any injury or ot cemetery, crematory or other place) JAN 15, 200 FREDDERCE MD Burial 2 ☐ Cremation 3 ☐ Removal from State FAIRVIEW COM. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility GARY L. LOULIN'S FUNCTIVE RUMB 21. Signature of Funeral Service Licensee ollis 110 WEST SOUTH ST FREDERICK MD 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final BREAST CANCER METASTATIC Pnysician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to for as a consequence of cause. Enter Underlying Cause (Disease or iinjury attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical or Attending Physician: The law requires that the death certificate be after death.

Director: After this certificate has been signed by the attending physicis P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? Dav 5 Other (specify) Pregnant at time of death 1 Yes 2 9 Unknown is certificate has been signed by the a director, page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🗌 No 1 Yes 2 No 1 Yes 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 28c. Injury at work? 1 ☐ Yes 2 ☐ No completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certificate: 5 Pending 1 Natural ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) the Hospital 24 hours a Funeral I Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check within 2 To the F 29d. Date signed (Month, Day, Year) 29b. Signature and title of 29c. License number 2 MD 200 61410

DHMH 17 Rev 7/2009

State

Registrar

TOLL HOUSE-HY, FREDERICK,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

CHAFFAR SYED

31. Date filed (Month, Day, Year)

JAN 14

			Flease	Type of Finit in b				•		
			For State	State of Maryland	•			ental Hygi	ene	00683
			Registrar		Cei	rtificate of I			g. No.C. U I U	
н	Physici	an	1. Decedent's Name (First, Middle, Las		>			Date of Death Month	n Day Year	3. Time of Death
1	/Medic		William	E. Rutt				1	(0 ZOIC	0 4:00 AM
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and the same			2003 E. Jeffer	son Street		Balto	If Under 24 Hrs.	0 D-1(D:1)	N/A	(04-4
	Funeral		5. Social Security Number 6. Se	7. Age (<i>In yrs. la</i> X M 2□ F		If Under 1 Year Months Days	Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Bi	irthpla <i>c</i> e (State or Foreign Country)
	Director		216-24-8763 Usual Residence of Decedent	∆ M 2□F 79	110.			2-29-1	1930	MD
	and		10a. State 10b. County	10c. City,	Town or Lo	cation				10d. Inside City Limits
	/aryl	5	MD	/- D-	1 - 1					1 ⊈Yes 2 ☐ No
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	with	٥							USA	•
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40	ter d	F	1 Never Married 2 X Married	Armed Forces? 1 ∐Yes 2√LNo	- 1		lispani <i>c</i> Origin? (Spec an, Mexi <i>c</i> an, Puerto F	Rican, etc.)	Black, Wh	ite, etc.
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21		mo:	12th grade	na	Br	ick La	yer			
b	be filed that Hygin of other event, III	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Name	(First, Middle, M	faiden Surname)	
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	To the Hospital or Attending Physiclan: he law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, p.ige 2		29a. Certifier 1 Certifying Ph	ysician: To the best of my know	vledge, deat	h occurred at the ti	me, date and place, a	and due to the c	ause(s) and manner	as stated.
	e Ho 1 24 t e Fui letely	Medical	(Check only 2 Medical Examone)	iner: On the basis of examinati and manner stated.	ion and/or ir	ivestigation, in my o	opinion, death occurre	ed at the time, da	ate and place, and d	ue to the cause(s)
	To the within 2 To the comple	₩	29b. Signature and title of certifier			29c. Licens	se number	2	9d. Date signed (Mo	nth, Day, Year)
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State Registrar 31. Date filed (Month, Day, Year)

30. Name and address of person who completed case of death (Item 23a) (Type, Print)

Matthew McNcbwen 4940 Eoste 5 Neg 4940 Eostern Ave Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State OT M	laryland / Depa			lental Hygi		00001
			Registrar 1. Decedent's Name (First, Middle, Last)	Cer	tificate of De	eath		g. N o.2010	
ı	Physicia Medic		Flora D Rice				2. Date of Death Month	Day 2 Year	3. Time of Death
	Examir		4a. Facility Name (if not institution, give street and number)	0.114	4b. City, Town, or Lo	ocation of Death		4c. County of Dea	ath
-	Funeral		University of Maryland Me 5. Social Security Number 6. Sex 7. Ac	e (In yrs. last birthday)		MORE f Under 24 Hrs.	8, Date of Birth	9 Ri	rthplace (State or Foreign
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	nd how at	្ក	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Loc	ation				10d. Inside City Limits
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36	within 72 hours after death with the Maryland glene. er than "natural", or items 23a or 28a-f sho the Mevical Examiner must be notified at		1 ☐ Never Married 2 🔀 Married Armed Forces? 1 ☐ Yes 2 ☐	•No	Yes, specify Cuban, N ☐ Yes 2 ☐ No 8	Mexican, Puerto F	Rican, etc.)	Black, Whi	
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Maryland 21215-0036	should and Me is mar raumati		19a. Informant's Name/Relationship (Type, Print)		g Address (Street and	Number or Rural	Route Number, C		ip Code)
	and 2 s Health tem 27		Marvin W. Edmonds-Brot	20b. Place of Dispos	Wilmot Stripp (Name of			21202 20c. Location - City o	r Town State
Baltimore,	Page 1		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		atory or other place)	i	-2010	Balto,	
Balt	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Marical Examiner must be notified at once.		21. Signature of Funeral Service Licensee		Name and Address of			East F/H Balto,	
			23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line	d the death. Do not ente					Approximate Interval Between
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ox 68760	auth certificate be executed attending physician and for use as the burial-transit	edical	Sequentially list conditions, and the cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Due to jor as Cause (Disease or linjury that initiated events resulting in death) Last C. Due to jor as d. Underlying Cause (Disease or linjury that initiated events resulting in death) Last 23c. If yes, outcome 1 ☐ Live Birth	a consequence of: a consequence of: of pregnancy 2 Fetal death 3	Ectopic pregnancy Other (specify)	AUNIZ		23d. Date of d Month	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of Maryland / Department of H		ntai Hygien	2010	00685
			Registrar 1. Decedent's Name (First, Middle, Las	Certificate of D		Reg. N	lo. 2 0 1 0	3. Time of Death
M.	Physicia Medic		Mary M.	Ray)ay Year	THE BALL
	Examin	ier	4a. Facility Name of not institution, give	street and number) 4b. City, Town, or I	ocation of Death	4	c. County of Deat	h A
	Funeral		5. Social Security Number 6. S	ex' 7. Age (<i>ln yrs. Mst birthday</i>) If Under 1 Year Months Days	f Under 24 Hrs. 8. Hours Min.	Date of Birth		thplace (State or Foreign
	Director		240-34-0923 1 Usual Residence of Decedent	Yrs. World's Days	Hours Will.	Month, Day Year	928 Nor	Th Carolina
	yland f show	호	10a. State 10b. County	10c. City, Town or Location				10d. Inside City Limits
	or 28a- notifie	Director	10e, Street and Number	A Baltimore		10- 0	Citizen of What Co	1 X Yes 2 No
	with the s 23a c ust be	Funeral	324 E. 22	2nd St. 3/3	1/8	10g. c	11.5	A
	r death ir item		11. Marital Status 1 ☐ Never Married 2 ☐ Married		panic Origin? (Specify Mexican, Puerto Rica	Yes or No- an, etc.)	14. Race - Amer Black, White	
21215-0036	72 hours after death with the Maryland "natural", or items 23a or 28a-f sho ledical Examiner must be notified at	ed by	3 Widowed 4 □ Divorced	1 ☐ Yes 2 🗖 No If Yes, Give 1 ☐ Yes 2 🕅 No Year or Dates.	Specify:		Specify:	ack
15-0	72 hou n "natu ledica	Completed	15. Decedent's E (Specify only highest gr	ade completed) (Give kind of work done du		16b.	Kind of Business I	Industry
212	within giene. er thai		Elementary/Seconday (0-12)	College (1-4 or 5+) life. DO NOT use retired)		P	rivate	Families
	e filed ntal Hy ed oth event	To Be	17. Father's Name (First, Middle, Last)	Cartt	18. Mother's Name (Fi		n Surname)	- 1
Maryland	should b and Me is mark aumatic	ľ	19a. Informant's Name/Relationship (T	(Spe, Print) (50n) 19b. Mailing Address (Street ar	lemp d Number or Bural Bo		or Town, State, Zio	Code)
	1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. if Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at.		Mr. Jeff	Ray 324 E. 22	nd St. B	alto.	nd. 21	1218
nore	o = to		20a. Method of Disposition 1 Burial 2 Cremation 3 2	20b. Place of Disposition (Name of cemetery crematory or other place	Date	~	Location - City or	Town, State
Baltimore,	permit. Pag Department Important: any injury o		4 ☐ Donation 5 ☐ Other (Special 21. Signature of Funeral Service License	22. Name and Address	of Facility	2010 Fa	ITVIEL	N N.C
m		1.0	+ Tatelle &	J. / hurris, J. M. 2222 W. N.	KUSSAFUE	. Dan	Homer!	21216
	Discountries		23a. Part 1. Enter the disease, or com shock, or heart failure. List only o Immediate Cause (Final		such as cardiac or re-	spiratory arrest,		Approximate Interval Between Onset and Death
	Physician/ Medical		disease or condition resulting in death)	a. Cholangitis				
				Due to (or as a consequence of):				
	Examiner	er	Sequentially list conditions,	b. Sepsis				Unhnown
1	Examiner	aminer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury					
b	Examiner	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Sepsis Due to (or as a consequence of): c. Hypotensor Due to (or as a consequence of):	ne d			Unknown 4-6 hours
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Division of Vital Records, P.O. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Certificate: To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a consequence of): C. Hypotenium Due to (or as a consequence of): d. Gasho Inteshnal 23c. If yes, outcome of pregnancy 1	te of Death (Check only A Nursing Home at 28d. as 2 No 28f. Idate and place, and du, death occurred at the ime, date and place, and under the ime, date and under the ime, date and place, and under the ime, date and under the ime, date and under the ime, date and under the ime, date and under the ime, date and under the ime, date and under the ime, date and under the ime, date and under the ime, date and under the ime, date and under the ime, date and under the ime, date and under the ime, date and	1 Yes 2 24a. Was an autopsy performed? 1 Yes 2 23d. Date of deliment of the Month of the Contribute to 2 No 3 Pr 24b. Were authorized to death? 1 Yes 6 Other (Specially occurred of Number or Rune) and manner as states, and due to the coses and manner as states igned (Month).	Unhous Ivery Day Year the cause of death? robably 4 □ Unknown topsy findings available completion of cause of 2 □ No ify) ral Route Number, ausse(s) and manner stated. stated. n. Day, Year)	
Division of Vital Records, P.O. Box 68760	Examiner	Medical Certificate: To Be Completed by Physician/Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a consequence of): C. Hypotenium Due to (or as a consequence of): d. Gasho Inteshnal 23c. If yes, outcome of pregnancy 1	te of Death (Check only A Nursing Home at 28d. as 2 No 28f. Idate and place, and du, death occurred at the ime, date and place, and under the ime, date and under the ime, date and place, and under the ime, date and under the ime, date and under the ime, date and under the ime, date and under the ime, date and under the ime, date and under the ime, date and under the ime, date and under the ime, date and under the ime, date and under the ime, date and under the ime, date and under the ime, date and	1 Yes 2 24a. Was an autopsy performed? 1 Yes 2 23d. Date of deliment of the Month of the Contribute to 2 No 3 Pr 24b. Were authorized to death? 1 Yes 6 Other (Specially occurred of Number or Rune) and manner as states, and due to the coses and manner as states igned (Month).	Unhous Ivery Day Year the cause of death? robably 4 □ Unknown topsy findings available completion of cause of 2 □ No ify) ral Route Number, ausse(s) and manner stated. stated. n. Day, Year)	

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Physici /Medic Examir

Funeral Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, it is Invalidated.

Physician /Medical Examiner

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

an al	VONZELLA TYLER RANDOLPH			JANUARY	14 2010 ar	3:15 A _M				
er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, o	or Location of Death	1	4c. County of Death					
	217 CENTER STREET		STATION		BALTIMORE					
	5. Social Security Number 6. Sex 1 □ M 3 ▼ F 7. Age (In yrs. last birthday Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 10/16/1		place (State or Foreign ntry) MD				
	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation				10d. Inside City Limits				
ō					1 X iYes 2 □ No					
rec	MD BALTIMORE TURNER 10e. Street and Number	STATION 10f. Zip Code		Dg. Citizen of What Country?						
Ö	217 CENTER STREET	2122	22		USA					
nera	11. Marital Status 12. Was Decedent Ever in U.S. 13.	. Was Decedent of I If Yes, specify Cub	Hispanic Origin? (S	pecify Yes or No-	14. Race - American Indian,					
Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🔂 No			o Mican, etc.)						
d by	3 Widowed 4 □ Divorced If Yes, Give Year or Dates:	1 □ Yes 2 🛣 No	оресну.		Specify: BLACK					
Be Completed by Funeral Director	15. Decedent's Education 16a. Deci (Specify only highest grade completed) (Give	edent's Usual Occu e <i>kind of work d</i> one DO NOT use retire	pation during most of wor	king 1	6b. Kind of Business/li	ndustry				
шb	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retire	(d)		EAUTY CHOD	OLIMED				
ပ္ပ	12 DEAU 17. Father's Name (First, Middle, Last)	TICIAN	18 Mother's Nam		EAUTY SHOP	OWNER				
) Be	LANZIE ALEXANDER TYLER		VONZELL		flaiden Surname)					
To		ling Address (Stree			City or Town, State, Z	p Code)				
					ION, MD 21					
		position (Name of ematory or other pla		Date 2	Oc. Location - City or T					
	Burlai 2 Li Cremation 3 Li Removal from State		1 1/5) 2010 C	CROWNSVILLE, MD					
		LLE VET (22. Name and Addre			RTON & SON					
	James 9. Whiten				, MD 21217	b 1.ii. Ino				
_	23a. Part 1 Enter the disease, or complications that caused the death. Do not en					Approximate Interval Between				
	shock, or heart failure. List only one cause on each line. Immediate Cause (Final	Geart F	wilung	Tempo.		Onset and Death				
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ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events									
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Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause gi	ven in Part I.	23e. Did toba	acco use contribute to	the cause of death?				
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o Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie	ent 3 DOA Ot	her:	th (Check only one		ifu				
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atio.	1 ☑ Natural 5 ☐ Pending (Month, Day, Year) Injury 2 ☐ Accident investigation		rkí?]Yes 2. □No							
ijį	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, s	street, factory, office		28f. Location (Str	eet and Number or Ru	ral Route Number,				
Sert	4 Homicide building, etc. (Specify)			City or Town,	Sidle)					
Medical Certification: To	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deal medical Examiner: On the basis of examination and/or and manner stated.									
Me	29b. Signature and title of certifier LAWSENCE BOAS M		se number		d. Date signed (Month					
	30. Name and address of person who completed cause of death (Item 23a) (Type LAW FENCE BUAS MID 54 Scutt AD)	Print) Rel (of Klessul	lle Md	21030					
e	31. Date filed (Month, Day, Year) 32. Redistrar's Signature		, ,,,,,	/	-					
ır	31. Date filed (Month, Day, Year) 32. Restrar's Signature JAN 15 2010 Surver A.	parker								

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Physician 13 MOUGE 2010 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner **Baltimore City** The Johns Hopkins Hospital If Under 1 Year | If Under 24 Hrs.

Months | Davs | Hours | Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Social Security Number . Age (In vrs. last birthday) **Funeral** Months Days 1 XM 2 F NY 060-46-3695 54 April 5,1955 Director Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland or 28a-f show notified at 10a. State 10c. City, Town or Location 1√ Yes 2 No Sterling MD Loudoun Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code ö must be r 20164 USA 112 Red Oak Lane Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☑ No 14. Race - American Indian, 11. Marital Status Black, White, etc. ed other than "natural", or ite 1 ☐ Never Married 2 ☑ Married White Baltimore, Maryland 21215-0036 Specity: Puerto Rican 1 Yes 2 □ No If Yes, Give Year or Dates: Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) al Hygiene. National Park Service 12 Photographer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) in and Mental F. Be Julio Ramirez T1177 Figuerda ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 112 Red Oak Lane, Sterling, VA 20164 Lavonne Luquis / Wife Health em 27 i Department of Health Important: If item 27 any injury or other tra 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 1/14/2010 Final Journey Crem. Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specity) of Funeral Service Licensee Dorota Marshall 22. Name and Address of Facility Maryland Cremation Services 21. Signature POBox 1413, Baltimore MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final rhosis Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy Day in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) 2 No 9 Unknown Division of Vital Records, P.O. 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? 2 🗌 No 2 No 26. Place of Death (Check only one) Be 25. Was case referred to medical Other: 4 Nursing Home 5 Residence 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 6 Other (Specify) မ 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 5 Pending investigation 1 Tes 2 No 2 Accident

or Attending Physician: after death.

Director: Aft
d in by the fu within 24 hours aft.

To the Funeral Dir

completely filled in the Hospital

Certification: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a. Certifier 1 🖊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier RES-000

DHMH 17 Rev 1/2001

State

Registrar

600 North Wolfe St, Baltimore, MD, 21287

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

JAN 15 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death January B, 2010 **Physician** Jill Andrea 1:00 PM Ross /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospice of Queen Anne's Centreville Queen Anne If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sept. 14, 1963 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 □ √F Director 386-82-5708 46 Michigan Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State in than "natural", or items 23a or 28a-f sho 1 ☐ Yes 2 🔽 No Director Queen Anne Grasonville 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 111 Canal Street 21638 USA permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s any injury or other traumatic event, the Wester Examiner mast by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married white 1 ☐ Yes 2X No Specify. Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 12 At Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Arthur Headlee Judith Woudstra ၉ 19a, Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph Ross-spouse 111 Canal Street-Grasonville, Maryland 21638 20c. Location - City or Town, State Date 20a. Method of Disposition 20b. Place of Disposition (Name of Evans Funeral Chapel and Cremation-Belair Jan. 13, 2010 Forest Hill, Maryland 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Name and Address of Eacilly ans Funeral Chapel and Cremation Services 300 Harford Road-Parkville, Maryland 21234 Eyans Tax Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ast **Physician** Concer 20 months /Medical Due t (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate saus. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 6 28a. Date of Injury (Month, Day, Year) 27. Manner of De 28b. Time of 28d. Describe how injury occurred House 28c. Injury at Work? 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

the Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760, cate has been s page 2 should within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, page

with the Maryland

Baltimore, Maryland 21215-0036

show

State Registrar

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

29b. Signature and title of certifier

DS2830

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jeanine MD Road #30, Amazolis, MO 2,40 werner

31. Date filed (Month, Day, Year)

29a. Certifier

(Check only one)

32. Resistrar's Signature Clever B

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM#17perFH, G899
1/15/2010 WS
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** 2010 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner GEN If Under 24 Hrs. MANAMONI 9. Birthplace (State or Foreign If Under 1 Year 8. Date of Birth (Month, Day, 6. 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. 1 □ M 2 🗹 F Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. inside City Limits 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any lojury or other traumatic event, the Wideral Evantinat must be notified at once. 10b. County 10a. State 1 ☐ Yes 2 II No Funeral Director 9 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number UNITED 210 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 No Maryland 21215-0036 If Yes, Give Year or Dates: 1 □Yes 2 🗹 No Specify: Specify: WH Completed by 3 ☑ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Libby Herbert ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 47 GYEN Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 Removal from State JAN 12 2010 FOREST 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensele

22. Name and Address of Facility

23. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. RFORD Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) assease sylventre Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if arry, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off. Examiner law requires that the death certificate be executed P.O. Box 68760 F ed by the attending physician and detached for use as the burial-trar Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 menths? 1 ☐ Yes 2 ☑ No 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. þ 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate h completely filled in by the funeral director, page 2 🗆 No 2 No 1 ☐ Yes 1 □Yes **Division of Vital** 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Amorton Be 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 ER/Outpatient 3 DOA 1 ☐ Yes 1 Inpatient Certification: To 27. Manuer of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who rho completed cause of death (Item 23a) (Type, Print) N Charles ST 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

ORIGINAL

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. and #29d Per Dyr G899 1/15/2010 JH State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 00690 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month MORRIS SPAMER EUGENE JANUARY 2010 3:00 P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death HARFORD FOREST HILL HEALTH & REHABILITATION FOREST HILL 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign **Funeral** 1 X M 2 □ F Days Hours 0472671921 88 MARYLAND **Director** 218-36-4267 28a-f shov 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland Examiner must be notified at Director 1 Yes 2 X No MD Harford Jarrettsville 10e. Street and Number 23a or 2 10g. Citizen of What Country? Completed by Funeral 1404 Baldwin Mill Road U.S.A. Page 1 and 2 should be filed within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black. White, etc. 1 Never Married 2 X Married ☐ Yes 'natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: White 3 Widowed 4 Divorced Year or Dates marked other than "natu matic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Mental Hygiene. Self-Employed Farmer and Excavator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Jasper Nobel Spamer Elizabeth Ferguson Patterson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health and tem 27 is r Linda M. Dewey (daughter) 1402 Baldwin Mill Road - Jarrettsville, MD 21084 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 X Burial 2 Cremation 3 Removal from State Spamer Cemetery 01/16/2010 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland . Signature of Funeral Service Licensee 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 11750 Belair Road - Kingsville, Maryland 21087 assa 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ er D J TA Je disease or condition resulting in death) Demenzi Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Physician/Medical Examine Due to (or as a consequence of): buriel-tran that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 the attending for use as IE FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) ed by the a g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 3 Suicide work? 1 ☐ Yes 2 ☐ No 5 \square Pending 24 hours after death. Funeral Director: A Investigation 6 Could not be in by t Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 24 hou

To the Fune

completed file only one) 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 2010 Down 13 3 5 522 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Division of Vital Records,

DAVID DUNN - 615 W. MACPHAIL ROAD, BEL AIR, MD 21014

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien

			1 - For State Registrar	State of Ma			rtment of H		fental Hy	ygien@ Reg. No.	010	00691
			Decedent's Name (First, Middle, La	ist)					2. Date of D	eath		3. Time of Death
	Physicia		Patricia M. Stei	nacker					Jan.	10 Day	2010	2:00 p M
	/Medic Examin		4a. Facility Name (If not institution, gire	re street and number)			4b. City, Town, or	Location of Death			County of Deat	
	Exami	Ο.	North Arundel Cor	v. Home			Glen Bur	nie		Anr	ne Arun	del
	Funeral	7	5 Social Security Number 6.5	Sex 7. Age	(In yrs. last birthe		If Under 1 Year	If Under 24 Hrs.	8. Date of B	irth		hplace (State or Foreign untry)
	Director		040-12-0901	1□ M 2XIF 86	Yr	s.	Months Days	Hours Min.	Mar. 2	27 192	24 Con	
P			Usual Residence of Decedent									
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×	- N	cto	MD Anne Ar	unaer	Glen Bu	TIII						1 ☐ Yes 2X No
ih f	or 28	Director	10e. Street and Number 313 Hospital Dri	170			10f. Zip Code				en of What Co	untry?
death with the Maryland	23a	a	313 HOSPICAL DII	.ve			21061			US	SA	
ep J	a H	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	Ever in U.S.	13. W If	as Decedent of Hi Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or N Rican, etc.)	lo- 1	 Race - Ame Black, White 	
affe o	a d	J.	1 Never Married 2 Married	1 ☐ Yes 2X N If Yes, Give	lo		☐Yes 2X No	Specify:			Specify: Wh	
DCCC Dours at	E N	d by	3 Widowed 4 ☐ Divorced	Year or Dates:								
22	nation	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)	(0	Give k	ent's Usual Occupa rind of work done o O NOT use retired	turina most of work	ing	16b. Kin	d of Business/	Industry
Z į	then.	Ę.	Elementary/Secondary (0-12)	College (1-4or 5-	Sec:)		Stat	e Empl	ovee
1 pe	lygie nt, II		17. Father's Name (First, Middle, Lasi	2			1	18. Mother's Nam	o /First Middl			-1
	d o d o	Be	Fredrick Moran	,				Ethel M.		e, maiden c	ourname)	
S Duoc	d Me nark natic	٩	19a. Informant's Name/Relationship	Time Driet	105.1	4 - 10				0	T	
Mai 32st	7 is r		Lindalee P.Ellic					und Number or Rur tain Way				up Code)
ם ה	Heat em 2 ther		20a. Method of Disposition		20b. Place of D	isposi	ition (Name of	1 - 1	Date		ation - City or	Town State
5 Sec	permit. Pages 1 and 2 should be flield within 72 hours after death with the Marylan permit. Pages 1 and 2 should be flield within 72 hours after death with the Marylan Important: If them 27 is marked other free "natural", or Items 23a or 28e-1 ehow any Injury or other traumatic event, the Modical Examinar must be notified at once.		1 ☐ Burial 2 Cremation 3 [Atlant:	crema	atory or other place	_{e)} 1–13.	10		Burni	
ATTITUDE rmit. Pages	ritani	1	4 ☐ Donation 5 ☐ Other (Special Signature of Auneral Service Lice		ACIAIL		Name and Addres	The Land				<u> </u>
	Impo any l		21. Signature Sitt directal Service Lice	" ex		_	arda F.H	20,		son St	.,Balt	imore, MD
			23a Part Enter the disease or con	olications that caused	the death Die				224	Orrost.		Approximate
			23a. Part1. Enter the disease, or conshock, or heart failure. List only	one cause on each lin	e.	1	i tile mode or dymi	y, such as cardiac	or respiratory	arrest,		Interval Between Onset and Death
	iysician Medical		Immediate Cause (Final disease or condition resulting in death)	a. HSpira	Tion /	L	ammen					
	kaminer			Due to (or as a	consequence of)	:						
		_	Sequentially list conditions,	b. De to (or as a consequence of):								
Ъ	ısıt	olu e	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	200 10 (01 43 2	consequence or	•						
recui	ohysicien and the burial-transit	Examiner	that initiated events resulting in death) Last	c. Due to (or as a	consequence of)							
9 8 8	icien	ᇤ		213 (4 (4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4	- asiioo qaaiioo ai,	•						
cate	phys.	dlcal		_ d								
Sertif	ding se as	/Me	IF FEMALE:	23c. If yes, outcome of	of pregnancy			error - merce				
agh (atten for u	lan	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal death		Ectopic pregnancy Other (specify)			23	3d. Date of deli Month	ivery Day Year
) a	the	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	ume or death	3 🗀 .	Other (specify)					
The law requires that the death certificate be executed	ed by the attending p detached for use as		Part II. Other significant conditions	contributing to death bu	t not resulting in th	ne uno	deriving cause give	en in Part I.	23e. Did	tobacco us	e contribute to	the cause of death?
Lires G	signed d be det	d b		•	•		, , ,			Yes 2		
5 §	should t	Completed							-			
i s	has Je 2	ם							24a. Wa auto	opsy	prior to o	topsy findings available completion of cause of
		8							1 ☐ Yes	formed? 2 No	death? 1 ☐ Yes	2 No
Physicien:	certificete has t	Be	25. Was case referred to medical examiner?	Lio opitali	** *		T Out	26. Place of Deat	h Check only	опе)		
P y	this a	٩	1 Yes 2 No		nt 2 ER/Outp			4 Nursing Ho				cify)
dlng	Atter	Certification:	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day	Year) 28b. Tim Inju		28c. Injury Work		28d. Describe	how injury	occurred	
tend .	tor:	Cat	2 Accident investigatio 3 Suicide 6 Could not b					/es 2 □No				
or Al	Direction by	Ħ	4 Homicide determined		ry - At home, farm . <i>(Specify)</i>	, stre€	et, factory, office			(Street and own, State)	Number or Ru	ıral Route Number,
pital	erel		29a. Certifier 1 Certifying Pl	l l	for the state of							
Hos	24 hours after death. • Funerel Director: After this certific etely filled in by the funeral director.	dical	(Check only one) 2 Medical Example (Check only one)	nysician: To the best o miner: On the basis of and manner stat	examination and/o	or inve	occurred at the time estigation, in my op	e, date and place, inion, death occur	and due to the red at the time	e cause(s) a , date and p	and manner as place, and due	to the cause(s)

State Registrar 29b. Signature and title of sertifi

Duffet S(A)
31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

ORIGINAL

29c. License number

D38958

Hwy Sw Clan Burne MD 21061

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2010 00692 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** Ruth R. Stancil 3:35 AM OI 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ST AGNES TIMORE HOSPITAL If Under 24 Hrs. Social Security Number 7. Age (In vrs. last birthday) f Unde Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** Hours Months Min. 1 □ M 2 T□ F Yrs. 67 216-38-4031 06-21-1942 MD **Director** Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 28a-f show rand Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show raumatic event, it a fredicht Examirer must be rediffed at Baltimore MD 1XXYes 2 □ No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 3310 Benson Ave., Apt G32 USA 21227 by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 72 hours after 1 Yes **2**No If Yes, Give Year or Dates: 1 Never Married Married Maryland 21215-0036 Specify: White 1 ☐ Yes 2 🔀 No Specify 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own home Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname)
Ruth R. Wener 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be filt Department of Health and Mental H Important: If item 27 is marked oth any Injury or other traumatic even Be John F. Roberts, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1905 Victory Dr., Baltimore, MD 21227 19a. Informant's Name/Relationship (Type. Print) Audrey Mitchell / Daughter altimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 01/18/2010 XXBurial 2 Cremation 3 Removal from State Loudon Park Cemetery Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Bailey Funeral Home and Cremation Service, PA Ma VE 12 M01452 4023 Annapolis Road, Halethorpe, MD 21227 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final 4days **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ner Due to (or as a consequence of): burial-transi Exami Due to (or as a consequence of) ンアANC / L , RU H K . Division of Vital Records, P.O. Box 68760, physician Physician/Medical as the IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month 5 Other (specify) the 2 No d be detache Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown FF COLITIS 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed cer ificate 2 **N**0 1 ☐ Yes 2 ☑ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours after death To the Funeral Director: filled in by the 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 🕊 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number MD P24065 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TOSPITAL, 900 CATORY ANE BALTIMORE AGNES JAHAN 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 1/200

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month 60.15 AM 2010 arles aurv 0 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Carroll Westminster Carroll Hospital Center Birthplace (State or Foreign Country) If Under 1 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Months Min 1⊠M 2□F 14, 1928 Maryland Dec. 219-42-6344 81 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10h. County 1 ☐ Yes 2 ☐XNo Westminster Maryland Carroll 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21158 U.S.A. 159 Ruth Shriver Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ∐Yes 2 1X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify Specify: 3 Widowed 4 Divorced White 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) dairy farmer 12 4 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ruth Lee French Charles M. Shriver, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Oueenstown, MD 21658 John W. Foster III/ nephew P.O. Box 105 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 → Burial 2 □ Cremation 3 □ Removal from State Druid Ridge Cemetery 1/16/2010 Pikesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hartzler Funeral Home 21. Signatur Funeral Service Lic an 310 Church St. New Windsor, MD 21776 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) HED Due to (or as a consequence of) Sequentially list conditions, if any leading to immediate Due to (or as a consequence of): d. Date of delivery Day Year

Physician /Medical Examiner

Physician

/Medical

Examiner

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evantine must be notified at once.

Baltimore, Maryland 21215-0036

Examiner sician and burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi Division of Vital Records, P.O. Box 68760, Physician/Medical δ Completed Be Certification: To

Cause (Disease or injury that initiated events resulting in death) Last	C	uence of):		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of d 9 ☐ Unknown	death 3 Ectopic pr		23
Part II. Other significant conditions Author contributing to death but not resulted by the Color for S	ulting in the underlying ca	use given in Part I.	23e. Did tobacco use 1 Yes 2 24a. Was an autopsy performed? 1 Yes 2 No	
25. Was case referred to medical examiner?	F - 11		26. Place of De	eath (Check only one)
1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3 DO	A Other: 4 \sum Nursing	Home 5 ☐ Residence 6 [
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigatio	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	3c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injury of
3 ☐ Suicide 6 ☐ Could not be determined		ome, farm, street, factory,	office	28f. Location (Street and City or Town, State)

cause of death (Item 23a) (Type, Print)

3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☑ No Other (Specify) occurred Number or Rural Route Number. 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier (Check only one) and manner stated. 29d, Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

contribute to the cause of death?

State Registrar

Medical

31. Date filed (Mo

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 2:34 P M Margaret Elizabeth Scott 2010 January 11, /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Harford Upper Chesapeake Medical Center Bel Air 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 84 1925 South Carolina **Director** 251**-**20**-**5399 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Examinar must by motified at 1 XYes 2 No Director Maryland Bel Air Harford 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21014 204 F Chaucer Lane Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2∑ If Yes, Give Year or Dates: 2 No 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🔀 No 2 Specify: 3 XWidowed 4 ☐ Divorced White Hygiene. other than "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Cosmetology Owner / Operator 12 Health and Mental Hygi em 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Irvin P. Kelly Edna (nmn) Carter 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and Department of Healtt Important: If Item 27 any Injury or other tr Dianne Cottrell / Daughter 770 Shore Drive, Joppa, MD 21085 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Highview Memorial Gdn: 1-15-10 Fallston, Maryland 22. Name and Address of Facility

McComas Funeral Home, P.A. 50 W. Broadway, Bel Air, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** nezma disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ruh Sequentially list conditions, Examiner Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) □Yes 2 No signed by the a 9 Unknown 9 Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s performe PRO certificate 1 ☐ Yes 2 XNo 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier TX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 2010 Name and address of person who completed cause of death (Item 23a) (Type, Print) W. MacPhai 615 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

DHMH 17 Rev 1/2001

t, Margaret Mocoolo50'

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #20b Spar of Maryland 1/15/2010 III Health and Mental Hygiene AMEND #27, PER ME G932 10/23 12 TRT Reg. No. 20 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year OOLO Month **Physician** 454pm 200 not Rosetta Elizabeth Tillery /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If,not institution, give street and number) Examiner N/ACita thispital 2:14 norte scitinuie >inai If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2√2√5 75 219-28-0239 Director 8, 1934 Maryland Oct Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 1 Yes 2 No Director Baltimore N/A Maryland 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number 21216 USA 2136 Braddish Ave Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 **X**No Specify: Black 1 ☐ Yes 2 ☐ No Specify: δ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Local 2016 Steel-College (1-4or 5+) Years Elementary/Secondary (0-12) Executive Assistant workers Union 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rosetta Nash Walter L. Jackson ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Rhonda Tillery-Davis/Daughter Camden Wyoming, Delaware 19934 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition 1/13/2010 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State King Memorial Park 1/14/2010 Woodlawn, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Chatman-Harris Funeral 5240 Reisterstown Rd Baltimore, MD 21. Signature of Funeral Service Lisen 23a. Par . Enter the Asease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and control in the cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Anoxic Physician المح disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last wes Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐Yes 2 ☐ No 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Disease 24a. Was an 1XYes 2□No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Yes 2 □ No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 XNatural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Decrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier (Check only one)

that the death certificate be execute Box 68760 P.O. Division of Vital Records, Hospital or Attending death. within 24 hours after death

To the Funeral Director:
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permit. Pages 1 and 2 Department of Health s Important: If item 27 is any injury or other tra

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Baltimore, Maryland

traumatic event, the Medical Examiner must be notified at

State Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of certifier

30. Name and address

31. Date filed (Month, Day,

Year)

KOZZ, MI

completed cause of death (Item 23a) (Type, Print)

CEIDO

32. Reg

29c. License number

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29d. Date signed (Month, Day, Year)

BUDGE

THUMPSON, AGNES B, 215601192

			For State Registrar	State of Maryland		artment of F <i>tificate of L</i>		Mental Hy	/giene Reg. N	21111	00696
	Dhunisia	/	Decedent's Name (First, Middle, La.					2. Date of D	eath		3. Time of Death
	Physicia Medi	cal	Agnes B. Thom					JAN.		3 2010	
	Examir	ner	4a. Facility Name (if not institution, give		_	4b. City, Town, or BALT:	LOCATION OF DEA		40	c. County of Death N	A
	Funeral Director		213-00-1192	ex 7. Age (<i>In yrs. l</i> as:	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		ay, Year)	9. Birth Cou M1	nplace (State or Foreign ntry)
	aryland a-f show fied at	Director	Usual Residence of Decedent 10a. State 10b. County MD N/A		Town or Loc						10d. Inside City Limits 1 Yes 2 □ No
	with the M 23a or 28 ust be noti	Funeral Dir	10e. Street and Number 5622 Ready Ave			10f. Zip Code 21212		•	10g. C	itizen of What Cou	intry?
-0036	is filed within 72 hours after death with the Maryland tal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	2	11. Marital Status 1 XNever Married 2 Married 3 Widowed 4 Divorced 15. Decedent's E	12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates.	1	Vas Decedent of Hi Yes, specify Cuba ☐ Yes 2 X No ent's Usual Occup.	n, Mexican, Puer Specify:	pecify Yes or No to Rican, etc.)		14. Race - Amer Black, White Specify: TiC Amer Kind of Business I	, etc. an ican
Maryland 21215-0036	within 72 h giene. ier than "n the Medi; the Medi	Completed	(Specify only highest gr Elementary/Seconday (0-12)		(Give H	ind of work done of NOT use retired) emaker	luring most of wo	rking	ī	Self	idustry
yland	Q F 3 0	To Be	17. Father's Name (First, Middle, Last) Ernest Thompso	n,Sr.			18. Mother's Na Mildre	me <i>(First, Middle</i> d Madi:		Surname)	
	shot and is n		19a. Informant's Name/Relationship (1 Adrian Thompso	n/Son	6023	g Address (Street a			, MI	21210	
Baltimore,	Page 1 nent of ant: If it		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Special Service User)	Removal from State Arde	ent C		1/1	Date 8 / 1 0	Har	nover, Mi	D
Ba	permit. Departr Imports any inju		District of the control of the contr		ے 5	Name and Addres	air Rd	rı P. (,Balt.,	CIOS , MD	e F.Sv: 21206-	s,PA 5105
	Pnysician Medical Examiner	iner	23a. Part 1. Enter the disease, or comshock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Usqueritally list conditions, if any, leading to immediate cause. Enter Underlying	plications that caused the death. ne cause on each line. a. ADULT RE Due to (or as a consequent Due to (or as a consequent Due to (or as a consequent)	SSPII	RATOR	y DIST			NDROME	Approximate Interval Between Onset and Death
00	cate be executed physician and the burial-transit	edical Examiner	Cause (Disease or linjury that initiated events resulting in death) Last	c	(or as a consequence of):						
Division of Vital Records, P.O. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and To the Funeral Director: After this certificate has been signed by the attending physician and completed filed in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnanc 1 ☐ Live Birth 2 ☐ Fetal c 4 ☐ Pregnant at time of dea	death 3	Ectopic pregnanc Other (specify)	у			23d. Date of deliment	ve ry Day Year
ls, P.0	uires that t n signed b ild be deta	þ	Part II. Other significant conditions of	ontributing to death but not result	ting in the u	nderlying cause giv	en in Part I.				the cause of death?
Record	The law req ate has bee page 2 shou	Completed						24a. Was auto perf 1 🗆 Yes	opsy ormed?	prior to c death?	opsy findings available ompletion of cause of
ital	ician: certific ector,	Be	25. Was case referred to medical examiner?	Hospital:			ace of Death (Che	ck only one)			
of V	Phys r this eral dir	2	1 Yes 2 No 27. Manner of Death	↑ Inpatient 2 ☐ El	R/Outpatien	t 3 DOA Othe	4 L Nursing	lome 5 Res		6 Other (Special	ý)
sion o	Attending r death. cctor: Afte by the fune	Certificate:	Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	(Month, Day, Year)	injury e, farm, stre	M 1 □				nd Number or Rura	al Route Number.
Δ <u>×</u>	pital or ours afte eral Dire			building, etc. (Specify)				City or To			
	thin 24 hos	Medical	(Check 2 L Medical Exam	sician: To the best of my knowled iner: On the basis of examination a se Practioner: To the best of my k	ind/or invest	igation, in my opinio	n, death occurred time, date and p	at the time, date	and place he cause	e, and due to the ca (s) and manner as s	ause(s) and manner stated stated.
	F ≥ F 2		> Alghan			RES	- DOO			ate signed (Month,	
			30. Name and address of person who ABHIJEET GHAT	OL Good Sounce	ritan	HOSD, 56	OI LOCK	Raver	BI	lvd. Bal	timore mi
	Sta Registr		31. Date filed (Month, Day, Yak) 1	5 2010 Hegistrans Signatur	<i>A</i> .	falls					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 1N6 Medical 4a. Facility Name (if not institution, give street and number, City, Town, or Location of Death 4c, County of Death Examiner IEN BURNIE ANNE AR . Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday 6. Sex **Funeral** 1 M 2 K Hours Min Dec. 21 Country) 220-15-5642 71 ,1938 China Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 X No MD Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6 Windy Hill Lane 21061 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examin Completed by 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. Asian Specify: 3 🗌 Widowed 4 🗆 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (3-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Yook Wong Yuk Lee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs Rosanna Chan /Daughter Windy Hill Lane Glen Burnie, MD 21061 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Lorraine Park Cem. 1 Burial 2 Cremation 3 Removal from State Januar 4 ☐ Donation 5 ☐ Other (Specify) 18, 2010 Woodlawn, Maryland 22. Name and Address of Facility Singleton Funeral & Cremation Services PA 1 2nd Ave. SW Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician disease or condition Medical resulting in death) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Exami and I-transi the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last ed by the attending physician a detached for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months 1 Yes 2 1 No Day Pregnant at time of death q Unknown 9 Unknown P.O. s been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 is autopsy performe 1 ☐ Yes 2 ☐ No Yes 2 N **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 1 Tyes 2 No ည 1 Inpatient 2 ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 1 Natural 5 Pending 2 🗌 No Μ 1 Tyes Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗀 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier son who completed cause of death (Item 23a) (Type,

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 0 0 6 9 8 Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month 12, Tritle 1:40 PM Peggy January 2010 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 9146 Lennings Lane Baltimore Rosedale 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Months Hours 1 □ M 2 1 F 171-28-8515 78 February 2, 1931 Pennsylvania Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 1 ☐ Yes 2 XNo Maryland Baltimore Rosedale 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21237 **USA** 9146 Lennings Lane 12. Was Decedent Ever in U.S. Armed Forces?
1 □ Yes 2 □ Wo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian 1 Never Married 2 Married 1 ☐ Yes 2 📉 No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Baltimore County School Teacher 12 years vears 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harold Dell Helen Leonard 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dr. Robert L. Tritle Husband 9146 Lennings Lane, Rosedale, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date January 1 XBurial 2 Cremation 3 Removal from State Haven Rest Memorial Park Shirleysburg, Pernsylvania 18, 2010 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fune al Service Licensee 22 Name and Address Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, MD. 21222

Physician /Medical Examiner law requires that the death certificate be executed

Physician

/Medical

Examiner

Director

Funeral

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Completed

Be

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Funeral

Director

show

Baltimore, Maryland 21215-0036

burial-trar attending physician for use as the burial signed by the a cate has by page 2 s certificate ă

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The

within 24 hours after death

To the Funeral Director:
completely filled in by the

23a. Part 1. Enter the disease, or comp shock, or heart failure. List odly Immediate Cause (Final disease or condition resulting in death)	olications that caused the death. It one cause on each line. a. Due to (or as a consequen	m	no of dying, such as cardia	c or respiratory a	arrest,	Approximate Interval Between Onset and Death
Sequentially list conditions,	b	ce of):				
Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a consequen	ce of):				
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 5 No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal de 4 Pregnant at time of deat 9 Unknown	ath 3 ☐ Ectopi	ic pregnancy (specify)			te of delivery onth Day Year
Part II. Other significant conditions o	ontributing to death but not resultin	g in the underlyin	g cause given in Part I.		tobacco use cont	ribute to the cause of death? 3 ☐ Probably 4 ☐ Unknown
					psy ormed?	Were autopsy findings available prior to completion of cause of death? 1 □Yes 2 □ No
25. Was case referred to medical examiner?			26. Place of Dea	ath (Check only	one)	
1 Yes 2√1No	Hospital: 1 ☐ Inpatient 2 ☐ ER	Outpatient 3□	DOA Other: 4 - Nursing H	lome 5 Res	idence 6 □Oth	ner (Specify)
27. Manner of Death	(Month, Day, Year)	b. Time of Injury M	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe	how injury occurr	red
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	, farm, street, fact	tory, office	28f. Location (City or To	(Street and Numb wn, State)	per or Rural Route Number,
29a. Certifier Certifying Ph	ysician: To the best of my knowle niner: On the basis of examination and manner stated.	dge, death occuri and/or investigat	red at the time, date and plac tion, in my opinion, death occi	e, and due to the urred at the time	e cause(s) and m., date and place,	anner as stated. and due to the cause(s)
29b. Signature and little of certifier			29c. License number		29d. Date signe	d (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year)

JAN 15 2010

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Perrick Taylor		1- For State	tate of Maryla				Mental H		201	0 00699
•		1. Decedent's Name (First, Mide		aylor				Date of Dea Month	ith Day Year	3. Time of Death 2302 hrs
Physician I Deceder Name (First, Middle, Last) Deteror Name (First, Middle, Midd		4c. County of I	Death							
		•				Months Days		1.	F	9. Birthplace (State or oreign Country)
' any		10a. State 10b. County						TO SALL A	7,1720	10d. Inside City Limits
faryland 28a-f shov at once.	ector	10e, Street and Number		В	Baltimo	10f. Zip Code		1	0g. Citizen of What	1 Yes 2 No
with the N ns 23a or ne notified			12. Was Dec		S. 13. Wa			pecify Yes or No	USA 14. Race - A	American Indian, Black,
after death al", or iten iner must l			1 Yes	2 No	1			Rican, etc.)	Specify: B	etc.
36 in 72 hours han "natur dical Exami	pleted t	Elementary/Secondary (0-12)			during m	ost of working life. D			16b. Kind of Busin	
5-00; led with Hygiene I other t	ပ	17. Father's Name (First, Middle			Tabol		3.Mother's Name	e (First, Middle, M	Constr Maiden Surname)	uction
12 Id be Mental Marke event				n	19b. Mailing	Address (Street a				State Zip Code)
MD d 2 sho lith and n 27 is aumati		Rhonda Tayl		T = 200 = 200	3912	? Eierma	n Ave.	Balto	,Md. 21	206
MOFE, Pages I an nent of He ant: If ite		1 X Burial 2 Cremation	/	nny State C	crematory or oth inity	er place) Cemeter	y Jan	.19,20	20c Location - Ci	o.Md.
		21 Squature of Funeral Service	Licensee	1166	22. N C a	ame and Address o	f Facility Scrug	gs Fun	eral Ho	me
/Medical		failure. List only one cause	on each line.		Do not enter th	ne mode of dying, su	reston uch as cardiac d	St B or respiratory arre	alto Md est, shock, of fleart	proximate Interval Between Onset and Death
Exammer		or condition resulting in death)		consequence of	·):					
. 1	miner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	С							
mand transit		events resulting in death) Last		consequence of):					
50, te be ex tysician	oυ ₽		#			G899,1/15/1	O.WS		22d Date of dal	
OX 687(eath certifical attending plots use as the	sician/	23b. Was decedent pregnant in the past 12 months?	1 Live bit	rth int at time of dea	2 Fet	_	Ectopic pregna	incy	23d. Date of del Month	Day Year
P.O. B s that the d	2	Part II. Other significant condit			sulting in the u	nderlying cause give	en in Part I.		bacco use contribut	e to the cause of death? Probably 4 Unknown
cords, law require has been si	npleted							24a. Was a	an 24b. Wer	e autopsy findings available to completion of cause of
I Re(n: The riffcate or, page		25. Was case referred to medica				26 Place of	Death (Check o	1 ✓ Yes 2		Yes 2 No
Vita Physicia r this cer	B B	examiner? 1 Yes 2 No	Hospital: 1 In		· · · · · · · · · · · · · · · · · · ·	3 DOA	hor: 🖂		Residence 6 C	Other:
ion of tending P leath tor: After the funer	티	1 Natural 5 Pend	ding Jan 10, 2	f Injury Day Year) 010						
Divis pital or At	Certificati	3 Suicide 6 Coul	d not be 28e. Place	of Injury - At ho Sidewalk	me, farm, stree	t, factory, office build	J.	or Town, St		r Rural Route Number, City re, MD
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical (hysician: To the best miner:On the basis of and manner sta	examination an						
	ž	29b. Signature and title of certifie	er 1 1 M	A		29c. License n			29d Date signed (
2	İ	30. Name and address of person Zabiullah Ali, M.D.	who completed cause Assistant Medica		*	Street, Baltim	ore, MD 212	201		
Sta Regist		31. Date filed (Month, Day, Year)	Seneva 32. Reg	istrarts Signat	and a					
w		*********		-	Later M.				OCME	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Reg. No. 2 0 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2010 Stella M. Unkart Рм **January** 1:10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bel Air Upper Chesapeake Medical Center Harford 8. Date of Birth (Month, Day, Year) Nov. 8, 1955 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Days Months Hours Min. 1 □ M 2 1 F 217-62-6254 Maryland Director Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State ed other than "natural", or items 23a or 28a-f show event, the "hadical Examinar in set be notified at PA Airville Director York 1 ☐ Yes 2 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code U.S.A. 7888 Woodbine 17 302 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2X No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐Yes 2X If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married white 1 ∐Yes 2X No Specify: þ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) State of Maryland Health Officer Secretary Is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Department of Health and Mental Important: If Item 27 Is marked any injury or other traumatic evonce. Blanche UNKNOWN UNKNOWN Woodrow 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7888 Woodbine Road, Airville, PA 17302 Albert Unkart/ Husband 20b. Place of Disposition (Name of cemetery, crematory or other place)
Evans Funeral Chapel
Bel Air 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Evans Funeral action Services 3 Newport Drive, Forest Hill, Maryland 21050 r 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mm diate Cause (Final Physician JRBHUSK JEARS ase or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ■ No Year Month Day 5 Other (specify) 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 X No 1 ☐ Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 Tyes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation after death Could not be determined 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 I Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Hospital or Attending Physician: The law requires that the death certificate be executed P.O. Box 68760. M00003314 Records, Vital Division of FENO within 24 ho

To the Fune

completely f

Baltimore, フンロフいこ

Registrar

29a. Certifier

(Check only one)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

500 Upper Chesapeake Drive Bel Air, IND 21014

29d. Date signed (Month, Day, Year)

Amend 19a, per Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** Datoni Wolff 2:38 A M January 14, 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Carroll Hospital Center Westminster Carro11 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Country)
Oct. 18, 1965 Maryland 5. Social Security Number 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 M X X F 44 220-86-5754 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 28a-f show 1 ☐ Yes 2X No traumatic event, the Medical Examiner must be notified Director Baltimore MD Owings Mills the 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ò death with 124 Fennington Circle 21117 23a U.S.A. Funeral items ; 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 72 hours after 1 ∐Yes XXXNo If Yes, Give Year or Dates: 1 Never Married XXMarried Baltimore, Maryland 21215-0036 1 □Yes XX No ò Specify Specify: Black þ 3 Widowed 4 Divorced 'natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be 1 Health and Mental George Stewart Yvonne Williams 19a. Informant's Name/Relationship (Type. Print)

John J. Wolfe / Hus 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John J. Husband 124 Fennington Circle, Owings Mills, MD 21117 27 permit. Pages 1 and Department of Healt Important: If Item 2' any Injury or other: once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Qther (Specify) Metro CrematoryInc: 1/15/10 Baltimore, MD 21. Signature of Fundamental Service I cense 22. Name and Address of Facility Eckhardt Funeral chapel P.A. 11605 Reisterstown Rd. Owings Mills, MD21117 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final metabolic encephalograthy **Physician** Iweek disease or condition resulting in death)) /Medical Due to (or as a consequence of): Examiner Methicalin Resident Staphalococcos Abrews seas u Levely Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending PhysIclan: The law requires that the death certificate be executed Zu edu 1891 Cellulita Ct and burial-trar Due to (or as a consequence of) Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) P.0. the 9 Unknown ģ signed to 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ğ CIRCHGAG 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 s autopsy certificate 1 □Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital this certific al director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident after death Director: , d in by the f 3 Suicide 6 □ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide n 24 hour⊾ the Funeral Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 0 1/04/2000 D31660 Xelva 19 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hemas k. Loestmusien many in Accord CU 31. Date filed (Month) 32. Registrar's Signature State Registrar

Registrar DHMH 17 Rev 1/2001

State

& NORTH AVE

BHY.4WUR

32. Registrar's Signature

A. park

M.

31. Date filed (Month, Day, Year)

BEL AIR MD 21014

State of Maryland / Separtment of Health and Mental Hygiene Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Tanuary **Physician** 140 PM James Wilson /Medical 4c. County of Death Eacility Name (If not institution, give street and number, Examiner N/A Imore Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs/ Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** 247-48-6022 **M** 2□ F 77 7,1932 Director S. Carolina April Usua! Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r than "natural", or items 23a or 28a-f show MD N/A Baltimore 1X Yes 2 □ No Director 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 2503 Violet Avenue #205South 21215 USA Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any mjury or other traumanc event, the Mydical Evanturing ODGS. 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ∐Yes **X**∭No Specify: Specify: ੬ Black 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th Grade College (1-4or 5+) Self-Employed Truck Driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Samuel Grant Odessa ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) James Shell/ Son 1147 N. Carey St. Baltimore, Maryland 21217 20c. Location - City or Town, State 20a. Method of Disposition Crownsyille Vet. Cem Greenmount Cemetery 1 XBurial 2 X Gremation 3 ☐ Removal from State Crownsville 4 □ Donation 5 □ Other (Specify) 1/18/1| Baltimore, 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Cnarman-Harris Funeral Home arre 5240 Reisterstown Road Baltimore, MD21215 29a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Ceuse (Final disease or condition resulting in death) **Physician** /Medical ue to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner provascular Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No ed by the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 **X** No 1 ☐ Yes 2 🗆 No 1 □ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🛣 No 2 ER/Outpatient 3 DOA Certification: To 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No filled in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. within 2 To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of cer Name and address of person who completed cause of death (Item 23a) (Type State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

	Amer	nd	Please #7 per Fh g899 1/1	Type or Print in E 9/10 TT State of Marylan	Black Indelib	le Ink. Ensure	All Copies	Are Legib	le.
			1 - State Amend #5, p	9710 TT State of Marylan er Fn g899	Certifica	ate of Death	J. Worker Fry	Reg. No.20	00704
П	Physici /Medic		1. Decedent's Name (First, Middle, Las		neeler	Jr.	2. Date of Dea Month	Day	Year 9:35 A M
)	Examin		4a. Facility Name (If not institution, give Longview Nurs			y, Town, or Location of De	ter	1	f Death
	Funeral Director		018-06 0901	7. Age (In yrs. 88 16	/ast birthday) If Und Month	er 1 Year If Under 24 F s Days Hours M	Irs. 8. Date of Birt in. (Month, Da	h y, Year) 0,1921 1	9. Birthplace (State or Foreign Country) Mary land
	show show	'n	Usual Residence of Decedent 10a. State 10b. County		ty, Town or Location	00.660			10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	or 28a-f	Director	10e. Street and Number	more	10f. 2	ip Code		10g. Citizen of Wh	
92	72 nous aner uean win ne maryand 'natural', or items 23a or 28a-f show deal Experiment must be redified at	y Funeral	3526 Mount 11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in U. Armed Forces? 1 ★Yes 2 No If Yes, Give	If Yes, sp	edent of Hispanic Origin? secify Cuban, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	14. Race Black, Specify:	- American Indian, White, etc.
2-003	natural",	sted by	3 N Widowed 4 □ Divorced 15. Decedent's Edi (Specify only highest grades)	Year or Dates:	16a. Decedent's Us		working	16b. Kind of Busi	white iness/Industry
2121	and Mental Hygiene. Is marked other than "r aumatic event, tre than"	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT	use retired) Presid	ent		Credit Bank
=	Mental Hygiene. arked other thar atic event, tre it	To Be	17. Father's Name (First, Middle, Last) Tordan De	est wheek	er, Sr.	18. Mother's N	Name (First, Middle,	Foste) 2.
			19a. Informant's Name/Relationship (7. Tordan B. Whee 20a. Method of Disposition	ler, III - Son	14005 J	ss (Street and Number or -ndian Ru ame of	T	. Darne:	State, Zip Code) Stown MD ZOS City or Town, State
	pernin. rages I and Department of Health Important: If item 27 any Injury or other tr once.		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License	Hemoval from State	emetery, crematory of	ervices - and Address of Facility To Funeral	16-2010	Forest	,
P	hysician		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	lications that caused the deat one cause on each line.	1690	4 York R	load, M	lonktor	Approximate Interval Between Onset and Death
€09.×	būrigi be	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a consequence) Due to (or as a consequence) Due to (or as a consequence)		tu Vasen	by ples	enc	25 gr
Records, P.O. Box 687	ned by the attending physic detached for use as the bu	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of o	Il death 3 🗆 Ectopio			23d. Date Mont	of delivery th Day Year
rds, P.	been signed b	þ	Part II. Other significant conditions co	ontributing to death but not res	ulting in the underlying	cause given in Part I.	23e. Did to	\ .	oute to the cause of death? B Probably 4 Unknown
		Completed						osy pr rmed? de	ere autopsy findings available ior to completion of cause of aath? □Yes 2 □No
of Vita	certificate rector, pag	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:		Othori	Death (Check only o		
n of		on: To	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day, Year)	ER/Outpatient 3 28b. Time of Injury	28c. Injury at Work?	g Home 5 Resid	now injury occurred	
Division	# : e	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		M ome, farm, street, facto	1 □Yes 2 □No	28f. Location (S City or Tox		r or Rural Route Number,
Hoenita	within 24 hours after de To the Funeral Directo completely filled in by the	edical C	29a. Certifier (Check only one) 1 Certifying Phy	rsician: To the best of my kno iner: On the basis of examina and manner stated.	owledge, death occurrent ation and/or investigati	ed at the time, date and plon, in my opinion, death o	ace, and due to the ccurred at the time,	cause(s) and mar date and place, ar	nner as stated. nd due to the cause(s)
Tothe	withir To th сотр	Me	29b. Signature and title of certifier	ndlet u	2	9c. License number		29d. Date signed	(Month, Day, Year)
1	ox1		30. Name and address of person who c	ompleted cause of death (Iter	n 23a) (Type, Brint)	Rd West	min ster.	MA	1157
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signa		R.	" (SICI)	THE ST	113/

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Alexander Month 6:11 PM **Physician** Eugene 2010 Januaru /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner Baltimore City** The Johns Hopkins Hospital Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) **Funeral** 1 **X**M 2 □ F Months Days Hours **Director** 56 JULY 23, 1953 218-62-6169 Usual Residence of Decedent 10d. Inside City Limits or 28a-f show notified at 10a State 10h County 10c. City. Town or Location 1 X Yes 2 □ No Director MD BALTIMORE 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? ö ral", or items 23a or Examiner must be Funeral 2818 E. FEDERAL ST. 21213 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: Black, White, etc. Pages 1 and 2 should be filed within 72 hours after cannot of Health and Mertal Hygiene.
ant: If item 27 is marked other than "natural", or iten
my or other traumatic event, the <u>Medical Examiner</u> 1 ☐ Never Married 2 😿 Married 1 ☐ Yes 2 ▼No Specify. à 3 Widowed 4 Divorced BLACK Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 MACHINE OPERATOR SUPERVISOR 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be GROVER ALEXANDER CALLIE COVINGTON ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) LYDIA ALEXANDER/WIFE 2818 E. FEDERAL ST. BALTIMORE, MD 21213 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Department of H
Important; If ite
any Injury or ott 1 ■ Burial 2 Cremation 3 Removal from State 1-20-2010 ST. STANISLAUS CEM. BALTIMORE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC. 21. Signature of Funeral Service Licensee BALTIMORE, MD 1701-31 LAURENS ST. 9. 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Ulmonary **Physician** hupertension disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sarcoidosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 🗌 Ectopic pregnancy Live birth 2 Fetal death in the past 12 months? Month Year Pregnant at time of death 5 Other (specity) 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed Be မ Certification:

The law requires that the death certificate be executed nding physician and use as the burial-tran Division of Vital Records, P.O. Box 68760. signed by the at has After this after death To the Hospital or within 24 hours at To the Funeral D

death with the Maryland

Baltimore, Maryland 21215-0036

should be page ; by the filled in

				24a. Was an autopsy performed? 1 □ Yes 2 ▼ No	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
25. Was case referred to medical			26. Place of De	ath (Check only one)	
examiner? 1 ☐ Yes 2 X No	Hospital: 1 Inpatient 2	☐ ER/Outpatient 3 ☐ DO	A Other: 4 - Nursing I	Home 5 Residence 6	□ Other (Specify)
27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of lnjury M	3c. Injury at Work? 1	28d. Describe how injury	occurred
3 ☐ Suicide 6 ☐ Could not be determined		nome, farm, street, factory, ify)	office	28f. Location (Street and City or Town, State)	d Number or Rural Route Number,
	ysician: To the best of my kn				and manner as stated. place, and due to the cause(s)

29c. License number

RES-000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) QUAN SUSAN

600 North Wolfe St, Baltimore, MD, 21287

lanuary

29d. Date signed (Month, Day, Year)

13

2010

State Registrar

DHMH 17 Rev 1/2001

Medical

32 Registrar's Signatur 31. Date filed (Month

and manner stated

29b. Signature and title of certifier

Registrar

State

M.D.,

32. Registrar's Si

Elizabeth Kingsley,

2002/Medical Parkway, Annapolis, Maryland 21401

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year A M 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Date of Birth 9. Birthplace (State or Foreign **Funeral** Director 23a or 28a-f show 10c. City Town or Location Raltimore 10d. Inside City Limits Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at 10a. State Director 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Was Decedent Ever In U.S 14 Race - American Indian Armed Forces 1 Never Married 2 Married þ 1 Yes 2
If Yes, Give
Year or Dates Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working plife. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) Armstrong ၉ unknown 19a. Informant's Name/Relationship (Type, Print 20a. Method of Disposition 20b. Place of Dispo cemetery, crep Page 1 a 1 M Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service 10155 23a. Part 1. Enter the disease, or complications that caused the death. Do not entertibe mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician. disease or condition resulting in death) laurc Medical Due to r as a consequence of Examiner Disens Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical that the death certificate be the as IF FEMALE: use 23c. If yes, outcome of pregnancy 1 \(\bigcup \) Live Birth 2 \(\bigcup \) Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month Pregnant at time of death 5 Other (specify) 2 No detached Unknown 9 Unknown P.O. I ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ate has been signed page 2 should be det 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, the Hospital or Attending Physician: The law requires Completed 1 🗌 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performe certificate 1 🗌 Yes within 24 hours after death.

To the Funeral Director: After this certific: completed filled in by the funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Tes 2 🗷 No မ J☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred Natural (Month, Day, Year) 5 Pending Accident Investigation 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 000 20T0

State Registrar

DHMH 17 Rev 7/2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JAN 19 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Auslander Physician/ Marcus 10:40 PM 001 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE SEASONS HOSPICE @ NORTHWEST HOSPITAL RANDALLSTOWN Birthplace (State or Foreign Country) MD Social Security Number 6. Sex 1 🕅 M 2 ☐ F If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** *d7728719*26 Director 219-18-1162 83 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo 1 ☐ Yes 2 🕅 No MD BALTIMORE PIKESVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3519 OVERBROOK ROAD 21208 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 If Yes, Give 1 Never Married 2 🕅 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify Specify: WHITE 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ **TEACHER** EDUCATION Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ EMANUEL MICHAEL AUSLANDER ROSE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15 QUEENBERRY WAY, BASKING RIDGE, NJ 07920 ANDREW AUSLANDER / SON 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 💢 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BETH TFILOH CONG. 1/14/2010 WOODLAWN, MD. 22. Name and Address of Facility SOL LEVINSON & BROS., I 8900 REISTERSTOWN ROAD, PIKESVILLE, MD. 21. Signal re Funeral Service License 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Atheroscierotic cardiovascular Disease Immediate Cause (Final -Pnysician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Exami that the death certificate be executed burial-transi that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical Box 68760 IF FFMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 - Fetal death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perform death? To the Hospital or Attending Physician: The I within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page ☐ Yes 2 ☐ No 25. Was case referred to edical Be 26. Place of Death (Check only one) examiner? ၉ 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manger of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred ✓ Natural 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Certifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated a Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) n S Rajupahse m.D. D0057465 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) , S, Raigpakse, M.D. 2835 Smith AV, Suite 203/Baltimore, MD. 21209. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 9 201 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 10:15 MPM Lillian Gail Babylon January Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Gilchrist Center for Hospice Care Towson Baltimore Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min. Days 1 M 2 M Months Hours (Month, Day, Year) Country) 59 Director 219-58-5749 Jul 30 1950 Maryland Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Directo 1 Yes 2 No ME Baltimore Middle River 10e. Street and Numbe 10f. Zip Code 23a or 10g. Citizen of What Country? Funeral 21220 United States Cypress Lane items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Black, White, etc. 1 Never Married 2 Married ō 2 1 ☐ Yes If Yes, Give 2 No within 72 hours after Maryland 21215-0036 1 Yes 2 hto Specify: "natural", 3 Widowed 4 ☐ Divorced Completed White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. 12 School Buses Driver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Howard Kenneth Wheat Nancy Unk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a Clara Holt /Friend Biscaynabay Blvd Middle River, MD 21220 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1 and Department of Pluportant: If ite injury or 1 Burial 2 Cremation 3 Removal from State Jan 16 4 Donation 5 Other (Specify) Beltsville, Maryland Chesapeake Crematory 2010 21. Signature of Funeral Service Licenses 22 Name and Address of Facility any Cremation and Funeral Alternatives Green Pastures Drive Towson 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause of each line. Immediate Cause (Final ancreatic Cornies Priysician/ disease or condition resulting in death) Medical Du to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ of Vital Records, Hospital or Attending Physician: The law requires cate has been sig , page 2 should b 1 ☐ Yes 2 ☐ No 3 🏋 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? certificate 1 Yes 2 No 2 🔀 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 \(\subseteq \text{ Yes} \quad 2 \) \(\text{No} \) Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\hat{\text{N}}\) Other (Specify) \(\text{W} \) Spl \(\text{W}\) မှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 \square Pending Division 1 Yes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 🔁 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one 29b. Signature and title of certifie wor 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

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			For	State of Ma	aryland / D	t indelible in epartment of <i>Certificate o</i>	Health and	Mental Hygie	ene2010 00°	710
		_	Registrar 1. Decedent's Name (First, Middle,	(act)		Certificate	Dealli	2. Date of Death	. No.	Dooth
	Physici /Medi		AGNE AGNE		スパナナ	NGHA	M.	Month	Day Year	
-0.4	Examir		4a. Facility Name (If not institution,	give street and number)		4b. City, Town	, or Location of Deat	h	4c. County of Death	
-	*		Bon Secours Hos				imore			
ı	Funeral Director		217-34-3276	. Sex 7. Ag 1 ☐ M 2 X F	e (In yrs, last birth	nday) If Under 1 Year Yrs. Months Day			9. Birthplace (State of Country) Maryland	r Foreign
	pur *		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location			10d, Inside Ci	ty Limits
	e Maryla 3a-f shor	ctor	MD Balti	nore		onsville			1 ☐ Yes	
	th with th	Funeral Director	10e. Street and Number 24 Casey Court			10f. Zip Cod	• 1228	100	g. Citizen of What Country? U.S.A.	
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinar must be nutflied at once.	by Funer	11. Marital Status 1 ☐ Never Married 2 ☐ Marrie 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 □ Yes 2 ☑ If Yes, Give Year or Dates:		13. Was Decedent of If Yes, specify C	of Hispanic Origin? (S uban, Mexican, Puert No <i>Specify:</i>	pecify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White	
2-00	72 hour	eted	15. Decedent's	Education	16a. [Decedent's Usual Oc (Give kind of work do life. DO NOT use ret	cupation ne during most of wor	rking	bb. Kind of Business/Industry	
21215-0036	d within rgiene. er than	Completed	Elementary/Secondary (0-12)	College (1-4or 5)+) [life. DO NOT use ret Data Proce			Medical	
Maryland	ld be file lental Hy ked oth	To Be (17. Father's Name (First, Middle, La Carl	st) Mens	ina		18. Mother's Nan	ne (First, Middle, Ma	^{iden Surname)} Davis	
ary.	shoul ind M i mar umat	-	19a. Informant's Name/Relationship			Mailing Address (Stre		ural Route Number, (City or Town, State, Zip Code)	
	alth a		Michael Day /	Son	24	Casey Co	urt, Caton	sville, M	D 21228	
Baltimore,	Pages 1 a nent of He nt: If item ry or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 4 ☑ Donation 5 ☐ Other (Spe		1	Disposition (Name of crematory or other p Gifts Regis	1		oc. Location - City or Town, State Hanover, Marylan	ıd.
Balti	permit. Departr Importa any Inju		21. Signature of Funeral Service Li		Traceing	22. Name and Ad	dress of Facility An	atomy Gif	ts Registry	
			23a. Part 1. Enter the disease, or co	emplications that caused	I the death. Do no	·			, Hanover, MD 21 t, Approximat Interval Bet	
1	Physician		shock, or heart failure. List or Immediate Cause (Final disease or condition	ly one cause on each li	with Ma	₹	, , , , , , , , , , , , , , , , , , , ,	, , , , , , , , , , , , , , , , , , , ,	Interval Bet Onset and I	ween Death
	/Medical Examiner		resulting in death)	Due to (or as	a consequence of	f):	DYAM	M: /F	1 LARININA	
		ē	Sequentially list conditions, if any, leading to immediate	b. METASTATIC SANAMONS CEZE CARCINUNG. Due to (or as a consequence or): c. ARTERINGLERITIC HEART DISEASE						
	be executed sician and burial-transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. ARTERINICLERITIC HEART DISE. Due to (or as a consequence of):					13EA3E	
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O. Box 68	o the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. o the Funeral Director: After this certificate has been signed by the attending physician and ompletely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant a	2 Fetal death	3 ☐ Ectopic pregna 5 ☐ Other (specify			23d. Date of delivery Month Day	Year
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on of	Itng Phys n. After this funeral di	ion: To	1 ☐ Yes 2 ☐ No 27. Manner of Death 1 ☐ Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ıry 28b. Tir	ime of jury 28c. In	4 □ Nursing H hjury at vork?	lome 5 Residen 28d. Describe how	ce 6 Other (Specify) injury occurred	
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	e Hospit 24 hour e Funera	Medical (29a. Certifier (Check only one) 1 Certifying 2 Medical Ex	Physician: To the best aminer: On the basis of and manner sta	f examination and	death occurred at the	e time, date and place ny opinion, death occu	e, and due to the cau urred at the time, dat	use(s) and manner as stated. e and place, and due to the cause(s	s)
	o th	Me	29b. Signature and title of certifier	// MI		29c. Lice	ense number	290	d. Date signed (Month, Day, Year)	

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

rint) Bon Becarrers Jevist. 1223

D 23300

JANUARY

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2, Date of Death 3. Time of Death Month Day Year **Physician** BROOKS JR. 10, 2010 DONALD STANLEY January P 9:46 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Greater Baltimore Medical Center Baltimore
9. Birthplace (State or Foreign Country) If Under 24 Hrs. 6. Sex 1 X M 2 ☐ F 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Months Min. Days Hours 58 Yrs. Director 217-56-1658 MAY 23 1951 MARÝLAND Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at Director 1 X Yes 2 □ No MARYLAND N/A BALTIMORE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. Funeral 3642 ELMLEY AVENUE Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 1∐Yes 2⊠No þ Specify: BLACK 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. int: If Item 27 Is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) 12th grade 2yrs MESSENGER PRIVATE Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be or other traumatic ပ DONALD S. BROOKS SR. IANTHA ALEXANDER 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 Is
any Injury or other trau 3642 Elmley Ave., Baltimore, Maryland 21213 Bernadette Brooks/Wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 01-16-10 BALTIMORE, MARYLAND KING MEMORIAL PARK 22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. 1206 W NORTH AVENUE Signature of Fune al Service Lige ulau Ant 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Ceuse (Final disease or condition resulting in death) **Physician** puncho 4000 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed work and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, signed by the attending physician by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 🗆 Ectopic pregnancy Month Day Year 5 Other (specify) ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown Completed After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner?
1 ☐ Yes Be 26. Place of Death (Check only one) Hospital: No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To Inpatient 2 ER/Outpatient 3 DOA 27. Manper of Death 1 Natural 2 Accident 28a Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 5 Pending investigation reral Director: A filled in by the fu 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and marning stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) <ec 31. Date filed (Month, Day, Year) 32 State Registrar

DHMH 17 Rev 1/2001

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Of IV	Ce	ertificate of L			leg. No.	00/12			
	Dhysisi		1. Decedent's Name (First, Middle, Last)				2. Date of Dea Month	th Day Year	3. Time of Death			
	Physicia /Medic		JULIUS BAT			January	14 2010	9:05 p M				
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or	Location of Death		4c. County of Dea	ath			
e mari			5021 PEMBRIDGE AVENUE 5. Social Security Number 6. Sex 7. A	ge (In yrs. last birthday	BALTIM If Under 1 Year	ORE If Under 24 Hrs.	N/A 9. Bi	rthplace (State or Foreign				
	Funeral Director		214-50-6303 Usual Residence of Decedent	61 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day MAY 12	(, Year)	RYLAND			
	land low											
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important; If item 27 is marked other than "natural", or items 23a or 28a-f show may injury or other traumatic event, the Medical Evanit or russt be routlied at once.	혅	MARYLAND N/A		BALTIM	ORE			1 XOX Yes 2 ☐ No			
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	23a	ral	5021 PEMBRIDGE AVE		212			U.S.A.				
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36	rs aft	ğ	XX Never Married 2 Married 1X Yes 2 If Yes, Give 3 Widowed 4 Divorced Year or Dates		1 □Yes 2 XX lo	Specify:		Specify: B	Specify: BLACK			
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E C	Pages nent of I int; If ite iry or o		XX Burial 2 ☐ Cremation 3 ☐ Removal from Stat 4 ☐ Donation 5 ☐ Other (Specify)	GARRISON		01-2	5-10	OWINGS MIL	LS, MARYLAND			
Baltimore,	permit. Departn Importa any Inju		21. Signature of Funeral Service Licensee	2	22 Name and Addres	s of Facility						
			23å Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dving, such as cardiac or respiratory arrest, Approximate									
	Physician		shock, or heart failure. List only one cause on each Immediate Cause (Final	line.					Onset and Death			
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Ö		Physician/	in the past 12 months? 1 □ Yes 2 □ No 4 □ Pregnant 9 □ Unknown 9 □ Unknown		Month	Day Teal						
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Records,	e law r has be ie 2 sh		Hyperlipider	nia			24a. Was autop	sy prior t	autopsy findings available o completion of cause of			
E H	cate l	Son	Diabetes performed? death? 1 yes 2 no									
Vital	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner? Hospital: Hospital:		Othe	26. Place of Deat						
of	Phys r this ral dii	5.	1 Yes 2 No Position 1 Inpatient 2 ER/Outpatient 3 DOA Outlet 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 1 Notatural 5 Pending (Month, Day, Year) 28b. Time of Injury Work?									
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Division	or Attendi ter death. irector: A n by the fu	Certification: To	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of I building,	njury - At home, farm, s etc. <i>(Sp</i> ec <i>ify)</i>	street, factory, office	reet, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State)						
	oital ours af	Cel	29a. Certifier 1 Certifying Physician: To the be	at of my knowledge, de	ath accurred at the tir	mo, data and place	and due to the	cauco(s) and manner	ae etated			
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate h completely filled in by the funeral director, page	Medical	(Check only one) 2 Medical Examiner: On the basis	of examination and/or	investigation, in my o	pinion, death occur	rred at the time,	date and place, and d	ue to the cause(s)			
								29d. Date signed (Month, Day, Year)				
	1		MANTIMO F	hysician		6817		1/15	12010			
	HV		30. Name and address of person who completed cause o	death (Item 23a) (Type	Print)	N. Gree	ene s	+ Balt.	ND 21201			
	Sta Registi			strar's Signature	back							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month O BEAMER **Physician** SANDRA 0100 2010 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 306 Bluewater Court Apt 104 Anne Arundel Glen Burnie 8. Date of Birth (Month, Day, Year) June 19, 1955 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex **Funeral** Min. 1 M 2 F Months Days Hours 54 Maryland 215-74-2039 Director Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location 28a-f shov Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Extrainer must be realised at 1 ☐ Yes 2 📉 No Director Zephyrhills Florida Pasco 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 33542 USA 39550 Sweetgum Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No 14. Race - American Indian. Black, White, etc. within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: Specify. Specify: ş 3X Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 1 and 2 should be filed within Health and Mental Hygiene. em 27 Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) 12 years Own Home Housewife 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Shirley Ann Weaver Andrew Ryan ೭ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11870 Triadelphia Road, Ellicott City, MD. 21042 Roland N. Reeley Jr. Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State January 21 20a. Method of Disposition permit. Pages 1
Department of H
Important: If Itel
any Injury or ott 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, Maryland 2010 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory ²² Name and Address of Facility al Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 21. St nature of Funeral Service Licenses Dundalk, Md. 21222 Approximate Interval Between Onset and Death 23a, Part 1. Enter the disease complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last Exami attending physician and for use as the burial-trar Due to (or as a consequence of): P.O. Box 68760; Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death The law requires that the death 3 Ectopic pregnancy in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) ☐Yes 2 No cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, \$ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 ☐Yes 2. No 2 No completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) tome Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Il or Attending Patter death. After Certification: 5 Pending investigation 1 Natural 1 □Yes 2 □ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a Hospital 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier **Medical** and manner stated. Date signed (Month, Day, Year) 29c. License number

State

DHMH 17 Rev 1/2001

2

Registrar JAN J

31. Date filed (Month, Day, Year,

JAN 19 2010 Senust S. par

M M

32. Registrar's Signature

Name and address of person who completed cause of death (Item 23a) (Type

10-00276 Rylee Erica Blac	kwe	Please Type or Print in Black Ind	elible Ink. Ensure All Copies Ar tment of Health and Mental Hygier	
Tylee Ellea Blac			ficate of Death	Reg. No.
Physicia Medical Exami	an/	1. Decedent's Name (First, Middle, Last) Rylee Evica Blackwell	2. Datu Mor Jan	e of Death nth Day Year uary 10, 2010 3. Time of Death 1010 hrs
)		4a. Facility Name (if not institution, give street and number) Sinai Hospital	4b. City, Town, or Location of Death Baltimore	4c. County of Death
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last	birthday) Yrs. If Under 1 Year If Under 24Hrs. 8. Days Months Days Hours Min.	1 2 2 2 2 4 9 Sirthplace (State or Foreign Country)
any (Usual Residence of Decedent 10a. State 10b. County 10c. City, To	own or Location	10d. Inside City Limits
3	ctor	10e. Street and Number	HMORE 10f. Zip Code	10g. Citizen of What Country?
death with the Maryland or items 23a or 28a-f show must be notified at once.	To Be Completed by Funeral Director	1749 Yakona Road	21234	USA
more, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland rent of Health and Mental Hygiene ant: If item 27 is marked other than "matural", or items 23a or 28a-fath or other traumatic event, the Medical Examiner must be notified at once		11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced of Pales:	13. Was Decedent of Hispanic Origin? (Specify Yolf Yes, specify Cuban, Mexican, Puerto Rican, 1 Yes 2 No specify:	etc.) 14. Race - American Indian, Black, White, etc. Specify: Black
2 hours afte "natural", Examine			 Decedent's Usual Occupation (Give kind of work do during most of working life. DO NOT use retired) 	ne 16b. Kind of Business/Industry
5-0036 led within 72 Hygiene. other than "		Elementary/Secondary (0-12) College (1-4 or 5+)	NIA	NIA
11215-0036 Id be filed within 72 hours after Aental Hygene, narked other than "natural", event, the Medical Examiner.		17. Father's Name (First, Middle, Last) Renarda Wilson	Nichelle D	Middle, Maiden Surname) Residuk Well
MD 21 d 2 should Ith and Me n 27 is ma umatic ev		19a. Informant's Name/Relationship (Type, Print) Nichelle D. Blackwell Mother		ile Maryland 21234
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed withi Department of Health and Mental Hygiene Important: If tiem 27 is marked other thingury or other traumante event, the Med		1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify:	ice of Disposition (Name of cemetery, matory of other place)	o Ralfimme Maryland
Balti permit. Departm Imports		21. Stinature of Theral Savice Licensee MO 1 5 5 3	22 Name and Address of Facility VOUGHM C. Greens FS./	2905 York Rd Sauland 21212
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do failure. List only one cause on each line.		Between Onset and
Examiner	iner	Immediate Cause (Final disease or condition resulting in death) a. Sudden unexplated Due to (or as a consequence of):	ined death in infancy (SU	DI)
		Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause		
kecuted n and ransit	l Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): d.		
ੂਲ ਲੋਫ਼ਾ	dical	X UNPENDED AMENDED 23a,27,28a-f,	perm,e g902 4/22/10 TT	
OX 68760, eath certificate be ex attending physician for use as the burial	sician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnant 1 Live birth 4 Pregnant at time of	2 Fetal death 3 Ectopic pregnancy	23d. Date of delivery Month Day Year
Box he death the attented for u	Physic	1 Yes 2 No 9 Unknown 9 Unknown	5 Other (Specify)	N. Didde to the second of death 2
F. P.O. ires that the signed by	ð	Part II. Other significant conditions contributing to death but not resu	ulting in the underlying cause given in Part I. 23	Be. Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 ✔ Unknown
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ital Recitions The land secretificate herector, page		25. Was case referred to medical	26.Place of Death (Check only one	✓ Yes 2 No 1 ✓ Yes 2 No
· Vita	To Be	examiner? 1 Ves 2 No Hospital: 1 Inpatient 2 VEF		e 5 Residence 6 Other:
ion of tending Pheath. tor: After the funeral		1 Natural 5 Pending F. 1 / 10 / 10 F.	8b. Time of Injury 28c. Injury at Work? 28d. D unk unk	escribe how injury occurred
Division pital or Atte cours after des terral Directo	ertification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) house in	e farm street factory office building etc. 28f Lo	ocation (Street and Number or Rural Route Number City Town, State) 2409 Loyola Northwa Baltimore, MD
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burn	Medical Co	29a. Certifier 1 Certifying Physician: To the best of my knowledge, one) 2 Medical Examiner: On the basis of examination and/	death occurred at the time, date and place, and due to for investigation, in my opinion, death occurred at the time.	the cause(s) and manner as stated.
To To	Me	29b. Signature and title of certifier	29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) January 11, 2010
		30. Name and address of person who completed cause of death (Item 23	· <u>()</u> .	
	ate	Theodore M. King, Jr., MD. Assistant Medical Example 31. Date filed Month Pag 72010 32. Registrar's Signature		21201
Regist	(E)	AUIT - A COLO VALLES VO. V.		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month January Jane Beach Betty 2010 3:50 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 1710 Dundalk Avenue Apt. B-6 Dundalk Baltimore Co. 5. Social Security Number 8. Date of Birth (Month, Day, March 1 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 9. Birthplace (State or Foreign 1 M 2 X F Months Hours Min. Director 213-52-5442 61 1948Usual Residence of Decedent should be filed within 72 hours after death with the Maryland and Mental Hyglene. It is marked other than "natural", or items 23a or 23a-f show aumatic event, the Medical Examiner must be notified at. 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 ☐XNo Dunda1k MD <u>Baltimore</u> 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1710 Dundalk Avenue 21222 Apt. B-6 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. ģ 1 Never Married 2 X Married 1 ☐ Yes 2X No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 🛣 No 3 Widowed 4 Divorced Specify: Completed Year or Dates White 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Restaurant Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Dorothy Norwood should be Marshall Gosnell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau (Husband) 21222 John M. Beach 1710 Dundalk Ave. Apt. B-6 Dundalk, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, prematory or other place) 20c. Location - City or Town, State 1 ☐XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, Wosp/ ct Cemetery 1/13/2010 Mt. Airey, Maryland 21. Signeture Funeral ervice L 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, 7922 Dundalk, Maryland Wise Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician Chsells disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): and burial-tran Exa Due to (or as a consequence of): resulting in death) Last the attending physician the for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Li Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregna☐ Other (specify) in the past 12 months?

1 Yes 22 No Ectopic pregnancy Day Pregnant at time of death s been signed by t should be detach Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has page 2 autopsy perform within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one, examiner? 1 🗌 Yes 2 ဂ္ဂ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 Kesidence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending work 1 Yes Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of person who completed cause of

Desau

MPMMM

31. Date filed (Month, Day, Year)

Box 68760

P.O.

Division of Vital Records,

death (Item 23a) (Type, Print)

January 11, 2010

21202

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2. Date of Death
Month
Day
January 12, 2010

3. Time of Death
1720 hrs

		Registrar	Certificate of Death Reg. No.											
Physici	ian/	1. Decedent's Name (First, Midd	ile,Last)						2	. Date of D	eath			3. Time of Death
edical Exam	iner	Michael David Barrett Month Day Year January 12, 2010 1720 h									1720 hrs			
		MICHAEL DAVID BALLECT							f Death					
		4007 Saint Monica Drive					Dundalk					2, 2010 1720 hrs 4c. County of Death Baltimore County th(MM/DD/YYYY) 9. Birthplace (State or Foreign Country) MD 10d. Inside City Limits 1		
		5. Conial Conveits Number	6. Sex	7. Age (In yrs	lost hid	thday)	If Under 1 Yea	or If Lindo	a 24Hea	9 Data of				
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	1	Usual Residence of Decedent												
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ylanc -fsh	Director	1 - 1 - 0 -	more	Du	nda	TK	405 75- 0-1-				T 20 0			
Mar. 28a	8	10e. Street and Number					10f. Zip Code				10g. Ci	tizen of vvn	at Count	TY?
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with	Funeral	11. Marital Status		cedent Ever in	U.S.		Decedent of Hi						- America	an Indian, Black,
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5-0036 iled within 7: Hygiene. I other than the Medical	ပိ	17. Father's Name (First, Middle	, Last)					18.Mother:	s Name (F	irst, Middle				7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7
21 be fill ntal I rked ent,	Be	Edward L. Ba	rrett	Sr				Too	~ ~ L L	е На	. 1 1			
21 uld buld b Mer mar	0	19a. Informant's Name/Relations	ship (Type, Print)	-	198	o. Mailing	Address (Stree	et and Num	ber or Ru	ral Route N	lumber, (City or Town	, State, 2	Zip Code)
MD 21; d 2 should b lth and Men n 27 is mar	10	V ₋			100									21222
und 2 salth em 2 raur		Jeanette Bar 20a. Method of Disposition	rett -	<u>Mother</u>	Place	of Disposit	CENTER tion (Name of ce	PLAC	e, 4	DE.	115	Ocation -	nda City or T	Lk MD
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Impentment of Health and Mental Hygiene. Important: If time I7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		1 Burial 2 Cremation	n 3 Removal t		cremat	ory or oth	er place)	interest,	'	Jale	7200.	Location -	City Of 1	JWII, State
Page ent c		4 Donation 5 Other S			avv	iew	Cremat	orvl	1_14	1_10	Ra	ltim	oro	MD
nit. artm		21. Signature of Funeral Service			1	22. Na	ame and Addres	s of Facility		17	7.04	T C T III	ore.	, MO
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Dhysisian	_	23a. Part I. Enter the disease, or	complications that	raused the deat	h Do no	PA,	2 3 4 e mode of dvino	W1 I	OW S	prir	ig R	oad,	217	
Physician / Medicar	0	failure. List only one cause	on each line.	oddocd tric dedi	n. Do ne	or or nor ur	o mode or dying	, 3001 03 00	ardide or r	copilatory	arrost, sr	ock, or rica	1	Between Onset and
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		or condition resulting in death)	Due to (or as	a consequence	of):									
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87 tifica ng pl		23b. Was decedent pregnant in the				Feta	al death 3	Ectopic	pregnano	v	1.		•	y Year
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AMENDED AME								Pr	28f Location (Street and Number or Rural Route Number, City or Town, State) 4007 Saint Monica					
								nd manner a	as stated					
								ace, and du	e to the	cause(s)				
To You	29d. Date signed (Month, D								, Day, Year)					
	January 13, 26													
		TAMERI/BRITIAL	(, M)				0.0.				Jai	idaiy 13,	2010	
		30. Name and address of person												
		Pamela E. Southall, M	1D Assistant	Medical Ex	amine	r 111	Penn Stree	t, Baltim	ore, MD	21201				
	tate	31. Date filed (Month, Day, Year)	32. ₽	egistrar's Signa	ture									

ORIGINAL

Registrar

		101	partment of Health and M		ible.
		Registrar	ertificate of Death	Reg. No. 2	10,00717
Physicia Medic		*	Bavota, Sr.	2. Date of Death Month Day January 13, 2	Year 010 3:59 A M
Examin	er	4a. Facility Name (if not institution, give street and number) 2127 Maple Road	4b. City, Town, or Location of Death	4c. County o	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Sparrows Poi	1t Balt 8. Date of Birth	imore Co. 9. Birthplace (State or Foreign
Director		214-22-1873	Months Days Hours Min.	(Month, Day, Year) July 6,1928	Country) Maryland
aryland a-f shov fied at	Director	10a. State 10b. County 10c. City, Town or L MD Baltimore	ocation Sparrows Poi	n†	10d. Inside City Limits 1 ☐ Yes 2 ☒ No
or 28	<u>=</u>	10e. Street and Number	10f. Zip Code	10g. Citizen of W	
with t	Funeral	2127 Maple Road	21219	United S	
death items ier mi		Armed Forces?	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	cify Yes or No- 14. Race	- American Indian,
after (", or xamir	d by	1 Never Married 21 Married 1 Yes 2 No	1 ☐ Yes 2 ☐ No Specify:	Specify:	, White, etc.
nours latura	Completed	lear of Dates.	edent's Usual Occupation	16b. Kind of Bu	White
n 72 h e. ian "n Medi	dmo	(Specify only highest grade completed) (Give	e kind of work done during most of worki DO NOT use retired)	ng Tob. Kind of Bus	silless illustry
i withi ygiene her th		7 Years Me	chanic	Refrige	rator Company
e filec ntal H ed otl	To Be	17. Father's Name (First, Middle, Last)		(First, Middle, Maiden Sumame)	
ould b	•	Joseph Bavota 19a. Informant's Name/Relationship (Type, Print)		a Mazzuchi	ata Zin Carta)
nd 2 sh ealth an m 27 is ner trau		Mrs. Mary Bavota (Wife) 212	ling Address (Street and Number or Rura 7 Maple Road Spar	rows Pt., Maryl	
permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: I fire Z7 is marked other than "natural", or items Z3a or Z8a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Dother (Specify) 20b. Place of Disposemetery, cre 4 Hilltop	osition (Name of grantory or other place) Service Corp. 1/14		City or Town, State Mary land
permit. Departm Departm Importa any inju			Name and Address of Facility Duda-Ruck Funeral 7922 Wise Ave.	Home of Dundal	
		23a, Part 4. Enter the disease, or complications that caused the death. Do not en	ter the mode of dving, such as cardiac o		Approximate
hysician/		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):	tery disease		Interval Between Onset and Death
Medical Examiner			•		1
sit sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying b. Due to (or as a consequence of):			
n and al-tran		Cause (Disease or iinjury that initiated events resulting in death) Last			-
te be e nysicia ne buri	dical	d			
rtifica ling pl e as tl	/Me	IF FEMALE:			
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Within 24 hours after death. When Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medi		☐ Ectopic pregnancy ☐ Other (specify)	23d. Date Mon	e of delivery th Day Year
that the ned by detact		Part II. Other significant conditions contributing to death but not resulting in the		23e. Did tobacco use contrit	oute to the cause of death?
quires en sigi vuld be	ted t	Bullows pemphigoid, Diabetes	Merins	1 X Yes 2 □ No 3	3 Probably 4 Unknown
e law rec s has be ge 2 sho	Completed by			autopsy pr	ere autopsy findings available ior to completion of cause of eath?
an: Th tificate tor, pa	Be Co	25. Was case referred to medical	26. Place of Death (Check	1 ☐ Yes 2 No 1	Yes 2 No
nysici lis cer direc	To B	examiner? 1	Othor	ne 5 Residence 6 Other	(Specify) MODICE
nding Pt tth. : After th e funeral		27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 28a. Date of injury (Month, Day, Year) 28b. Time of injury (Month, Day, Year)		8d. Describe how injury occurred	
al or Atters after destal Director	l Certificate:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Street and Number City or Town, State)	or Rural Route Number,
ne Hospif n 24 hour ne Funera pleted fill	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death 2 Medical Examiner: On the basis of examination and/or invesorily one) 3 Certifying Nurse Practioner: To the best of my knowledge,	stigation, in my opinion, death occurred at	the time, date and place, and due	to the cause(s) and manner stated.
Voithi Com		29b. Signature and title of certifier Augustus	29c. License number		(Month, Day, Year)
101		30. Name and address of person who completed cause of death (Item 23a) (Type,	Print) Charles ST	an vosus	
Stat	e	31. Date filed (Month, Day, Year) 32/Registrar's Signature			
Registra		JAN 19 2010 Lemm S. for	all .		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. edent's Name (First, Middle, Last) 2. Date of Death BURDETT ne of Death M Physician/ 2010 Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Medical Center Annapolis Anne Arundel 8. Date of Birth (Month, Day, Year) 02-05-1929 9. Birthplace (State or Foreign Country) Mary Land If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours 1 DM 2 ZF Director 80 Yrs. 213-26-1024 Usual Residence of Decedent should be filed within 72 hours after death with the Maryland and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits at Director ural", or items 23a or 28a-f s Examiner must be notified 1 Yes 2 No MD Annapolis <u> Anne Arundel</u> 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 124 <u>Dumbarton Drive</u> 21403 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2X No
If Yes, Give Black, White, etc. 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: 3 Widowed 4 Divorced Year or Dates White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) 12 Administrative Secretary Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be t Department of Health and Mental Important: If Item 27 is marked any Injury or other traumatic ev once. မှ John Rutter Elsie Butler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 124 Dumbarton Drive Annapolis, Maryland 21403 Harold Burdett / Husband Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🗆 Burial 2 🛛 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Crematory 01-15-2010 Odenton, Maryland Funeral Service License 22. Name and Address of Facility Donaldson Funeral Home & Crematory, P.A. 1411 Annapolis Road Odenton, Maryland 23a P 11 Inter the disease, or complication. That caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, slock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Year Day 9 Unknown P.O. Part II. Other significant conditions contributing to death but not tesulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? To Be Completed by Division of Vital Records. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Yes 2 No 2 🔲 No 1 🗌 Yes filled in by the funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) 2 No Other: 1 Yes Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide s after death Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical 1/2 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one)

Registrar

29b. Signature and title of certific

of person who

cause of death (Item 23a) (Type

D V1438

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

	1 - For State Registrar	State of N		Cer	tificate of l	Death	T	Reg. No. 2) 0	00/19	
ian/ ical	1. Decedent's Name (First, Middle ELOISE	BENA					2. Date of De Month JANUAY2U	Day	Year 2010	3. Time of Death 20: 42 PM	
iner	4a. Facility Name (if not institution	,	11A1 CE	N ITCO		r Location of Death	C	4c. Coun	ty of Death		
	JOHNS HOPKINS I 5. Social Security Number		ge (In yrs. las		If Under 1 Year	TIMORE If Under 24 Hrs.	8. Date of Bir		N/A	place (State or Foreign	
r	163-24-7297	1 □ M 2 🔀 F	83	Yrs.	Months Days	Hours Min.	(Month, Da	y, Year) 0.1926	Coun	nsylvania	
٦	Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Loc	eation	-			1	0d. Inside City Limits	
To Be Completed by Funeral Director	MD]	Baltimore			Dun	da1k				1 ☐ Yes 2 ☒ No	
ΙΘ	10e. Street and Number				10f. Zip Code			10g. Citizen of	f What Cour	ntry?	
Funeral	7446 Lawrence				212			Unite	ed Sta	tes	
by Fu	11. Marital Status1 ☐ Never Married 2 ☐ Ma	12. Was Decedent Armed Forces rried 1 ☐ Yes 24	Ever in U.S.			lispanic Origin? (Spe an, Mexican, Puerto			ace - Americ ack, White,		
ed b	3 ☑ Widowed 4 ☐ Divorce	If Von Give	1140	1	☐ Yes 2X No	Specify:		Specif	fy:	White	
Completed		ent's Education est grade completed)			ent's Usual Occup	ation during most of worki	ina	16b. Kind of	Business Inc		
l e	Elementary/Seconday (0-12)	College (1-4 or	5+)	life. DO	O NOT use retired)	annig moot or work	ng :		tment		
Be (12 Years 17. Father's Name (First, Middle,	Last)			Clerk	18. Mother's Name	e (First Middle		Vehi	cles	
ピ	John Herring				ry Live		.,,,				
	19a. Informant's Name/Relations					and Number or Rura					
		Son)								MD 21162	
	20a. Method of Disposition 1 Burial 2X Cremation	3 Removal from State	e cer	netery, crem	sition (Name of natory or other place	ce)	Date	20c. Location			
	4 ☐ Donation 5 ☐ Other (<u>//</u>			Corp. 1/1.				ryland	
	A Begar	C' Kin	2		Duda-Rud 7922 W	ss of Facility Ck Funera Lse Ave	l Home Dundali	of Dund k, Mary	lalk, land	Inc. 21222	
	23a. Part 1. Enter ma disease, o shock, or haa failur List	omplications that cause nly one cause on each lin	d the death.	Do not ente						Approximate Interval Between	
	Immediate Cau (Final disease or condition resulting in death)	_ a _ ACUTE	PESP	PATOR	24 DISTRE	SS SUNDE	OME			Onset and Death	
1	resulting in death)	Due to (or as		,	J	139				1 -	
je	if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of):									VEARS	
Examiner	Cause (Disease or iinjury that initiated events c.										
cal E	resulting in death) Last Due to (or as a consequence of):										
		d					_				
	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnance	у				23d D	ate of delive	erv	
sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 ☐ Pregnant :	2 ∐ Fetal of dea	ath 5	Ectopic pregnand Other (specify)	EY				Day Year	
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Completed by											
lete							24a. Was a			sy findings available	
l mo			-,-			-	autop perfo	rmed?	prior to con death?	npletion of cause of	
	25. Was case referred to medical examiner?				26. Pla	ace of Death (Check	1 \(\sum \) Yes only one)	2 W No	1 🗌 Yes	2 LJ NO	
유	1 ☐ Yes 2 ☑ No 27. Manner of Death		ient 2 🗆 El			4 L Nursing Hol	me 5 Resid	ence 6 🗆 Oth	ner (Specify)		
Certificate:	1 ☑ Natural 5 ☐ Pendir			8b. Time of injury	28c. Injury work M 1		28d, Describe h	ow injury occur	red		
Įį	2 Accident Investi 3 Suicide 6 Could 4 Homicide determ	not be 28e. Place of Inj		e, farm, stree			28f. Location (S	treet and Numb	ber or Rural	Route Number,	
		building, et	c. (Specify)				City or Tow	n, State)			
Medical	(Uneck 2 in Medicar E	Physician: To the best of examiner: On the basis of e	examination a	nd/or investi	gation, in my opinic	n, death occurred at	the time, date a	nd place, and du	ue to the cau	se(s) and manner stated.	
	only one) 3 Certifying 29b. Signature and title of certifier	only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
1 1						-000		JANUAY			
	Mulissa D 30. Name and address of person	who completed cause of c	leath (Item 2	3a) (Type, Pr	int)				J		
П	MELISSA MORGAN	MD 4940 E	ASTERN	J AVEN	LUE BALT	IMORE MD	21224				
te	31. Date filed (Month, Pax Year)	32. Fegistr	ar's Signatur	е, ——	-						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 19:00 PM Howard W. Baynard, 2010 CI Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death ood Samanitan MOSPITEN Balti more 6. Sex 1 X M 2 D F 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Days Min. Director 217-09-4034 Apr. (918 Maryland Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director 1 🗌 Yes 2 🙀 No MD Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 22 Turnbrook Court 21234 USA Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 ☐ Yes 2 ☒ No If Yes, Give "natural", or 1 Never Married 2 X Married Completed by Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 Tes 2 No Specify: 3 Divorced 4 Divorced white Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Engineer <u>Martin Marietta</u> Important: If item 27 is marked other any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mental Howard W. Baynard, Sr. Florence Keller NAPD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Connie M. Baynard wife Turnbrook Court: Baltimore. MD 21234 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Donation 3 Removal from State 4 Donation 1 Cremation 3 Removal from State A Other (Specify) Parkwood Cemeterv 1/16/10 Parkville, MD 21. Signature of 22. Name and Address of Facility 1050 York Road Towson, MD 21204 Ruck Towson Funeral Home. Inc. hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on each line. 23a, Part 1, Enter the disease, or complications shock, or heart failure. List only one cause Interval Between Immediate Cause (Final Onset and Death ROSEPSIS Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner enlure Sequentially list conditions, cause. Enter Underlying Exami the Hespital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No 3 ☐ Ectopic pregna5 ☐ Other (specify) Ectopic pregnancy Month signed by the at d be detached for 9 Unknown Part I<mark>I. Other significant condition</mark>s contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown sate has been się page 2 should b Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Yes Yes 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? Other: 1 Inpatient 2 မ ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural Natural 5 Pending injury work? 1 🗌 Yes 2 🗆 No Accident Investigation Suicide 6 🗌 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) within 24 hours a To the Funeral L Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 23986 UMPS MID 2010 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Loch Raven RIVA Mishan Rudrappa Good Samanlan Mospital Bauti more 21239 31. Date filed (Month, Day, Year) State Registrar

OMARD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 \(\) State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Antoni Budzko 14 AM 7:20 Jan. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Center Towson Baltimore Social Security Number 6 Sex 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year 1 🛛 M 2 🗆 F Months Director 218-44-9846 83 ຶ່ງ 926 Poland Mar. Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1XX Yes 2 □ No Md N/A Baltimore City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6409 Moyer Avenue 21206 Poland Poland 13. Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 X Married 1 Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Divorced Specify. Completed White Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Welder |Turnbull Enterprises Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Andrew Budzko Monczak Karolina 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Ann Stevenson/Daughter 18206 Bunker Hill Rd. Parkton, Maryland 21120 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Parkwood Cemetery 1/18/10 Baltimore, Maryland 21. Signature of Funeral Service Licers de 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Dangerho Onset and Death Physician/ disease or condition resulting in death) minth Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death signed by the at d be detached for 9 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of page 2 autopsy performed? Yes 2 No death? After this certificate 2 🗌 No 1 🗌 Yes Hospital or Attending Physician: funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 🗌 Yes 2 X No Other: ပု 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 N Other (Specify) NO OLG 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 \square Pending work? 2 No Accident Investigation 24 hours after death Funeral Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical de 29a, Certifie Detrifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the within 2 only one 29b. Signature and title of certifie 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles St Towson W CHARLES 6701 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2010 6:13 РМ Elizabeth Mary Botzler January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Lorien Mays Chapel Timonium 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1 □ M 2 🕶 F **Director** 218-40-2032 82 August 17,1927 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County f Health and Mental Hyglene. Item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Madical Expension must be notified at 1 □Yes 2 No Director Maryland Baltimore Lutherville 10g. Citizen of What Country? 10e. Street and Number Funeral 1502 Charmuth Road 21093 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Maritai Status Black, White, etc. 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by 3 Vidowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Domestic Service Domestic Worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ္ Park **Allender** Marv Lauer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Timonium, Maryland Mary Catherine Rose Daughter 20 Blondell Court 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Saters Baptist 20c. Location - City or Town, State Date Department of H Important: If ite any Injury or ot once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lutherville Maryland Church Cemetery 21. Signatore p Funeral Service Licensee 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Towson, Marvland 21204 1050 York Road Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only the cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Ta Physician/Medical Examiner Due to for as a consequence of Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 No 24a. Was an 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred I or Attending F after death. Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours at To the Funeral D 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one 29b. Signature and the of certi 29c. License number 29d. Date signed (Month, Day, Year) Chap RO79544 1-14-10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STE 4109 31. Date filed (Month, Day, Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Bolewicki ٧. Margaret January 2010 8:10 ам Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Gilchrist Towson Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🔀 F Months Hours July I'v, Day, ^{re}1924 Director 213-20-7021 85 Pennsylvania Usual Residence of Decedent show Page 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits ms 23a or 28a-f s must be notified Md. Baltimore Cockeysville 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10881 York Rd. 21030 USA "natural", or items 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 Yes If Yes, Give 1 ☐ Yes 2X No Specify: 3 - Widowed 4 Divorced Specify: White Year or Dates other traumatic event, the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Health Care Nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည George H. Coughlin Geraldine Eckweiler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 102 W. Pennsylvania Ave Ste. 600 Towson, Md. Mr. Craig P. Ward/ Attorney 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) Parkwood Cemetery 1-19-10 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Md. permit. 21. Signature of Juneral evice Licensee 22. Name and Address of Facility on Funeral Home, 1050 York Rd. Towson, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between O set and Death Immediate Cause (Final Ph_sician/ disease or condition resulting in death) dications OM of acute ▶ Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death Month 5 Other (specify) 9 Unknown cate has been signed by page 2 should be detach Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. þ 23e. Did tobacco use contribute to the cause of death? Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of autopsy perform death? certificate 2 🗌 No ☐ Yes 2 X No 1 🗌 Yes director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 🔽 No Other: 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work?
1 Yes Accident
Suicide 2 🗌 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined

within 24 hours a

To the Funeral C

completed filled

the

Registrar DHMH 17 Rev 7/2009

State

Medical

29a. Certifier

(Check only one)

31. Date filed (Month

29b. Signature and title of certifier

Man

Gn

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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N. Charles

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Towson

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

R149194

MD

January 15, 2010

21204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Januari ZOIC Medical City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner ltimore 8. Date of Birth 7. Age (In yrs. last birthday) 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** Min. 1 M 2 D F Hours Director 28a-f shov 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at Director Raltimore 1 Yes 2 □ No MD 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 21223 Funeral USA Edmondson 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Bace - American Indian. 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? Black, White, etc. 1 Never Married 2 Married þ 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates Specify: Black 3 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 t. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event". (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Bethlehem Steel Inter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည _ee annie 20b. Place of Disposition (Name of cemetery, crematory or other 20c. Location - City or Town, State 20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Other (Specify) Funeral Service 21. Signatur Balto. 23a. Par 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shook, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death Physician/ Ventricular disease or condition resulting in death) Dri mins Medical **Examiner** ardiolascu Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death nse 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? completed filled in by the funeral director, page 2 should be detached for Day Unknown the been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tes 2 No 3 Probably 4 Unknown the Hospital or Attending Physician: The law requires Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has performed? 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 No မ 1 ☐ Inpatient 2 A ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director: After 1 Natural 2 Accider 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier Welman

Registrar
DHMH 17 Rev 7/2009

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year

			_ FOI	aryland / Department of Healt		giene
			State Registrar	Certificate of Dea		Reg. No. U U U I Z 3
	Physicia	an	1. Decedent's Name (First, Middle, Last)		2. Date of De Month	Day Year 3. Time of Death
	/Medic	al	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Locati	ion of Death	4c. County of Death
	Examin	er	4411 SONNGDALE	AIR PALTIN	7012	NA
Т	Funeral		5. Social Security Number 6. Sex	Months Days Hou	nder 24 Hrs. 8. Date of Bir urs Min. Month, Da	th 9. Birthplace (State or Foreign Couptry)
	Director		Usual Residence of Decedent	95 Yrs. Monato Sayo	July	7,1927 N. CAPUHNA
	yland how		10a. State 10b. County	10c. City, Town or Location		10d. Inside City Limits
	e Mar 8a-f s	Director	MD NA	DALIMON_		1 ☐ Yes 2 ☐ No
	with the	Dir	111411 Process Mann 17	10f. Zip Code	フ	10g. Citizen of What Country?
	ms 23	Funeral	11. Marital Status 12. Was Deceder	Ever in U.S. 13. Was Decedent of Hispanic If Yes, specify Cuban, Mex	C Origin? (Specify Yes or No	o- 14. Race - American Indian,
9	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show it, the Medical Examinat must be motified at		Armed Forces 1 Never Married 2 Married 1 Yes 2 If Yes, Give	No 1 □Yes 2 12 No Specify Cuban, Mex		Black, White, etc. Specify: 43/A/
215-0036	hours tural",	ed by	3 Widowed 4 □ Divorced Year or Dates 15. Decedent's Education	16a. Decedent's Usual Occupation		16b. Kind of Business/Industry
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Baltimore, Maryland	be be eve	Be o	17. Father's Name (First, Middle, Last)	18. M	Nother's Name (First, Middle	A PA
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Ĭ,	12 tra		JOYCE CLEARY	44/1 90BINGE	PALE ME,	BALTI, MP, 21207
ore	of H of H f Ree		20a. Method of Disposition 1	20b. Place of Disposition (flame of cemetery, crematory or other place)	Date /	20c. Location - City or Town, State
ᆵ	Par ant: ury		4 □ Donation / 5 □ Other (Specify)	22. Name and Address of F	1-00-2010	Counsille, MD
g	permit. Departi Imports any inj		21. Signature of Funeral Service Licensoe	CARRY P. MORE!	H FILL BRAN AD	ME VA BOLLIND
			23a. Part I. Enley the disease, or complications that caus shock, or leart failure. List only one cause on each	d the death. Do not enter the mode of dying, such	h as cardiac or respiratory a	interval between
Same.	Physician		Immediate use (Final disease or condition	zheimer's Deme	Mia	Onset and Death
	/Medical Examiner		resulting in death) Due to (or a	s a consequence of):		
20	*	jer	Sequentially list conditions, if any, leading to in resolute	s a consequence of):		
	cuted nd ransit	Examiner	dary, leading to in redistrictions of the following cause. Enter Underlying Cause (Disease or injury that initiated events c.			
, 00	cate be executed ohysician and the burial-transit		resulting in death) Last Due to (or a	s a consequence of):		
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Box	leath certifica attending ph for use as th	M/us	IF FEMALE: 23b. Was decedent pregnant	e of pregnancy 2 ☐ Fetal death 3 ☐ Ectopic pregnancy		23d. Date of delivery
о В	The law requires that the death certificate be executed the has been signed by the attending physician and age 2 should be detached for use as the burial-transit	Physician/Me		at time of death 5 Other (specify)		Month Day Year
<u>. </u>	w requires that the d been signed by the should be detached		Part II. Other significant conditions contributing to death	but not resulting in the underlying cause given in P	Part I. 23e. Did	tobacco use contribute to the cause of death?
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		Som			perf 1 □ Yes	ormed? death?
VIta	ysician; iis certific director,	Be (25. Was case referred to medical examiner?	Othor	Place of Death (Check only	
ō	Phys er this eral dir	. To	27. Manner of Death 28a. Date of Ir	jury 28b. Time of 28c. Injury at		how injury occurred
<u>o</u>	nding F ath. r: After ie funera	atior	1 Natural 5 Pending (Month, L	lnjury Work? M 1 □Yes	2 No	
Division of	or Atte fer de irecto n by tf	Certification: To	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of I building,	njury - At home, farm, street, factory, office stc. (Specify)	28f. Location City or To	(Street and Number or Rural Route Number, wn, State)
	Hospital or Attending Physician: 44 hours after death. Funeral Director: After this certificately filled in by the funeral director, to		29a. Certifier Certifying Physician: To the be-	t of my knowledge, death occurred at the time, da	ate and place, and due to the	e cause(s) and manner as stated.
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical		of examination and/or investigation, in my opinion		
	To the within the company of the com	Ž	29b. Signature and title of certifier	29c. License numb	ber	29d. Date signed (Month, Day, Year)
				// 3 /	728	Jenuary 19 2010
			30. Name and address of person who completed cause of Rubbant King by M.D. 2	death (Item 23a) (Type, Print) 175 W S Royce John trans Signature	Avenue B	c) Timore Mondend
	Sta		31. Date filed (Month, Day, Year) 32. Region	trar's Signature		The state of the s
	Registr	ar	JAN 1 9 2010 Den	wa B. Marie		

DHMH 17 Rev 1/2001

or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760 after death.

Director: / 24 hours a Hospital

within 24

Registrar

State

Medical

29b. Signature and title of certifier RESIDENT 1 29c. License number RES 001

1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

2010

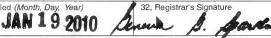
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SYED MUSTAFA AHMED 3001 & HANDVER ST, BALTIMORE MD

31. Date filed (Month, Day, Year)

29a. Certifier

(Check only one)



and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician Sarah S. Chandler January 11, 2010 9:45 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Keswick MultiCare Center Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Min. | March 25, 1924 Birthplace (State or Foreign Country) MD 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 □ M 213-30-7102 85 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits MD N/A XXYes 2 □ No Director Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2721 Atkinson Street 21211 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2XXIo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black White etc. 1 ☐ Never Married 2 ☐ Married White 1 ☐ Yes 2√2No Specify: þ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Bar Maid Avenue Tavern 4th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Harry Joseph Sullivan Mary Emma Zepp ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Taylor (Daughter) 2721 Atkinson Street Balto. MD 21211 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Atlantic Crematory 1/16/10 4 □ Donation 5 □ Other (Specify) Glen Burnie, MD 21. Signature of Funeral Service Vicence 22. Name and Address of Facility Furgee-Henss-Seitz Funeral H 3631 Falls Road Balto, MD Home, 2 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) In openable Coronory ortery Due to (or as a consequence of): Endstage Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner euitzopno. Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9∏Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☑ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? 1□ Yes

Physician /Medical Examiner

Funeral

Director

show

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If fisen 273 a or 28a-f show Important: If them 273 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at

Saltimore, Maryland 21215-0036

P.O. Box 68760.

Records,

Division or Vital

death certificate be

burial-trar physician the as. for use signed by the a this Hospital or Attending P 24 hours after death. Funeral Director: After t After

þ Completed 25. Was case referred to medical examiner? Be 27. Man er of Death

1 Yes

atural

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

29b. Signature and title

2 No

5 Pending investigation

6 ☐ Could not be

filled in by the

Certification: To

Medical

To the Hospital within 24 hours at To the Funeral D completely

State Registrar

31. Date filed (Month, Day,

30. Name and address of person

1600 W. MT. Posistrar's Signature

who completed cause of death (Item 23a) (Type, Print)

1 Inpatient

28a. Date of Injury (Month, Day Year)

and mariner stated.

GYAL AUE BACTIMONE.

DHMH 17 Rev 1/2001

2 ER/Outpatient 3 DOA

28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

1 ☐ Yes 2 ☐ No

0064788

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

			Please T Amend #1 per M	ype or Print in Bla D _g900 _2/25/10 State of Maryland/	ick Indelible Ink.	Ensure All Co	pies A	re Legible.	
			For State Registrar	State of Maryland 7	Certificate of De			0010	00700
			1. Decedent's Name (First, Middle, Last)	Millegan Jr. C		2. Date	Reg. of Death	1-5-10	3. Time of Death
and the same	Physicia Medio		Millegan Ju	Mior Cobia	<u> </u>			Day 2010	
أعاريب	Examin	er	4a. Eacility Name (ii) Hot institution, give str	ice	4b. City, Town, or Lo	son		4c. County of Death	
ı,	Funeral Director		5. Social Security Number 251. 56. 1750 6. Sex 1 Visual Residence of Decedent	M 2 \square F		f Under 24 Hrs. 8. Date Hours Min. (Mon	of Birth th Day Yea	9. Birti Cou	hplace (State or Foreign Intry) SC
	land show dat	tor	10a. State 10b. County		wn or Location				10d. Inside City Limits
	e Mary r 28a-1 notifie	Director	MD N/A 10e. Street and Number		altimore				1 Yes 2 □ No
	e filed within 72 hours after death with the Maryland that Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral I	261 Garrison Box		40	216		Citizen of What Co	A
9	er deal or iter miner	by Fu	11. Marital Status 1 ☐ Never Married 2 ☒ Married	2. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ♣ No		Mexican, Puerto Rican, etc	or No- c.)	14. Race - Amer Black, White	
003	urs aft tural", al Exa	ted t	3 🗆 Widowed 4 🗆 Divorced	If Yes, Give Year or Dates.	1 🗌 Yes 2 🔀 No 🥸	Specify:		Specify: 12	ack
21215-0036	an "na Medic	Completed	15. Decedent's Educ (Specify only highest grade	completed)	 ia. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 		16b	. Kind of Business I	ndustry
	led within Hygiene. other tha ent, the N		Elementary/Seconday (0-12)	College (1-4 or 5+)	Finishe	<u> </u>	F	acchinal	Construction
Maryland	uld be filed Mental Hy narked oth	To Be	17. Father's Name (First, Middle, Last)			3. Mother's Name (First, M Eddie V. Ba		en Surname)	
ary	1 and 2 should be fi of Health and Menta item 27 is marked other traumatic ev		19a. Informant's Name/Relationship (Type	, Print) 19	9b. Mailing Address (Street and			or Town, State, Zip	Code)
	and 2 s Health tem 27 i		Rosie A. Cobia/n	rife 2		mlevard, Apt			
Baltimore,			20a. Method of Disposition 1 Burial 2 Cremation 3 Re	comet	of Disposition (Name of tery, crematory or other place) Lawn Cemeter	V 01/21/20	- 1	Location - City or T	0.0
altir	permit. Page Department of Important: If any injury or once.		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee	IVVUX	22. Name and Address of	of Facility Vuluary			weral sics
8	8 8 E 8 8	lii i	Vaugh C. L		8728 LIB	erty Road I	Zano		MD21133
ı,			23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final	ations that caused the death. Do cause on each line.	not enter the mode of dying, s	such as ardiac or respirate	ory arrest,		Approximate Interval Between Onset and Death
	Medical		disease or condition resulting in death)	Due to (or as a equence	OP HOC	+ Tailu	رو		Years
	Examiner	ŗ.	Sequentially list conditions, b.	Posts (assessment)	.0.				
	rted 1 Insit	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Due to (or as a consequence	e or):			ia ia	
	executed ian and urial-transit		that initiated events c. resulting in death) Last	Due to (or as a consequence	of):				
092	cate be physic the bu	edica	d.						
Box 68760	certific	JW/W	200. Was decedent pregnant	c. If yes, outcome of pregnancy 1 □ Live Birth 2 □ Fetal dea	th 2 Deterio emenor			23d. Date of deli	very
Boy	Physician: The law requires that the death certificate be this certificate has been signed by the attending physici ral director, page 2 should be detached for use as the bu	Physician/Medical	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant at time of death 9 Unknown			_ i	Month	Day Year
P.O.	hat the led by t detach	by Ph	Part II. Other significant conditions contr	ributing to death but not resulting	in the underlying cause given	in Part I, 23e.	Did tobacc	o use contribute to	the cause of death?
ds, l	quires t en sign tuld be	ted b					1 🗌 Yes	2 No 3 Pro	obably 4 Unknown
Division of Vital Records,	has be te 2 sho	Completed					Was an autopsy	prior to c	opsy findings available ompletion of cause of
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isio	Attender deat or deat ector: by the	Certificate:	 Accident Investigation Suicide 6 □ Could not be Homicide determined 	28e. Place of Injury - At home, f		28f. Locat	8f. Location (Street and Number or Rural Route Number,		
<u>></u>	To the Nospital or Attending Physician: The is within 24 hours after death. To the Funeral Director: After this certificate his completed filled in by the funeral director, page		i i	building, etc. (Specify)			or Town, Sta		
\	e Hosp 124 ho e Fune	Medical	(Check 2 Medical Examiner	an: To the best of my knowledge • On the basis of examination and/ Practioner: To the best of my know	or investigation, in my opinion, c	death occurred at the time, o	date and pla	ace, and due to the ca	ause(s) and manner stated.
)	Vithir Comp	- 1	29b. Signature and title of certifier	Total of the Book of the know	29c. License nu			Date signed (Month	
			Pour Bush	MD	<u> 1 D68</u>	104		1/13/	2010
			30. Name and address of person who com	pleted cause of death (Item 23a)	-ks St, Sui-	Pe 4105,	Bol	Pimore.	mj) 21204
	Stat Registra	٠	31. Date filed (Month, Day, Year) JAN 19 2010	32. Registrar's Signature	21	1			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Year THEL COATES 12:46 PM 10 20:0 Medical ANUAG 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death SOHING HOPKING BAYVIEW MEDKAL CENTER BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth Date of bill. (Month, Day, Y 9. Birthplace (State or Foreign **Funeral** Country) Maryland 1 M 2 🙀 F Months Days Hours Min. Director 953 217-62-4430 Aug. Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1310 Delvale Avenue 21222 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 72 hours after þ 1 Never Married 2 TMarried Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: 3 Divorced Specify: Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) <u>School Bus Driver</u> Baltimore Co. Years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F ည Ethel Marie Portner Charles Tawney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 s Health a Mr. William F. Coates (Husband) 1310 Delvale Ave. Dundalk, Maryland 21222 injury or other Baltimore. tem 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a Department of H Important: If ite any injury or ott Date 20c. Location - City or Town. State cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Holly Hill Mem. Gdns. 1/15/2009 Middle River, MD Funeral Service Licens 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, 7922 Wise Ave. Dundalk, Maryland 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or beart failure. List only one cause on each line. Approximate nterval Between Immediate Cause (Final disease or condition Onset and Death Pnysician ATHEROSCLEROTIC VASCULAR D Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Due to for as a nonsequence off cause. Enter Underlying Examir or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events -tran Due to (or as a consequence of): resulting in death) Last nding physician a use as the burial Physician/Medical Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Por Month Day Pregnant at time of death the i 9 Unknown 9 Unknown P.O. been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an Were autopsy findings available prior to completion of cause of page 2 s autopsv death? certificate 1 ☐ Yes 2 ☐ No Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No 유 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury s after death. 1 Yes 2 No by the f Investigation Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) filled in 24 hours a Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed 3 🗆 within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signatu 10069223 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

150

Registrar

State

JUAN A

31. Date filed (Month, Day

MALALES

4940

32. Redistrar's Signature

EASTERN AVENUE BACTIMONE, MD ZIZZY

- TO DAES

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #10asta to Perar Han 6899 epart 16 12010 Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 5:10 AM Dode MAE 15 2010 01 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PIKESUITE If Under 1 Year | If Under 24 F BALTIMORE NURSING Home Year If Under 24 Hrs.
Days Hours Min. 5. Social Security Number 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Funeral 1 □ M 2 F Months Days 223-32-7286 Usual Residence of Decedent 8/ 03/23/1928 Director VIRGINIA 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show at BALTIMORE Pikes ville 1 ☐ Yes 2 No Examiner must be notified Director 10e. Street and Number Rockridge 10g. Citizen of What Country? 72 hours after death with items 23a or U.S.A. 21208 Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 Ho If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married Specify: BLACK 1 □ Yes 20 No ò Baltimore, Maryland 21215-0036 Specify: by 3. Widowed 4 □ Divorced "natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry other traumatic event, the Medical 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 5 Department of Health and Mental Hygiene. Important: If item 27 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) Homemaker HOUSE KEEPING 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be STAPLES CLARENCE LENORA HOW IKES 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2/208 19a. Informant's Name/Relationship (Type. Print) Kesuille, MARYIAND SON Juseph Dodson 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State The DERRICKE JONES FIH, P.A. BALTIMORE NAM'L CENE injury o 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee any ir 4611 PARK HOTS. AVE, BALLIMORR, MARVIAND 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final AAVANCED **Physician** Dementie disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Linter tridentifies Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner be executed and burial-trar Due to (or as a consequence of): Box 68760, physician Physician/Medical the as attending use 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy for Month in the past 12 months? 1 ☐ Yes 2 ☒ No Year Day 4□Pregnant at time of death 5 Other (specify) P.0. the 9□ Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 1 Yes 2 No 3 Probably 4 Unknown Completed been: 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an nası page 2 autopsy performed? Yes 20 No certificate | Division or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other:

Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 1 🔲 Inpatient this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: Hospital or Attending 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. DERNE 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) J, Sano 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 1/2001

CRNP 2835

	Division of Vital Records, P.O. Box 68760,	
	To the Hospital or Attending Physician: The law requires that the death certificate be executed	E
	within 24 hours after death.	ca
	To the Funeral Director: After this certificate has been signed by the attending physician and	m
٧	completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	in

		State of Maryland / Department of H								
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/Medica			or Location of Death							
<i>-</i>		Monthwest Hospital Center Rain	tallstown Baltimore							
Funeral		5. Social Security Number 6. Sex 1 Age (In yrs. last birthday) If Under 1 Year 10–26–9618 1 M 2 IF 74 Yrs. Months Days	If Under 24 Hrs. 8. Date of Birth Hours Min. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country)							
Director		Usual Residence of Decedent	Feb. 11, 1935 NY							
yland		10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits							
e Mar 3a-fsl	Director	MD Baltimore Owing	gs Mills 1□Yes 2√2 No							
		10e. Street and Number 35 Chase Mills Circle	21117 10g. Citizen of What Country? USA							
death	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of H If Yes, specify Cuba	Hispanic Origin? (Specify Yes or No- lan, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.							
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and 2 s ealth ar n 27 is			s Circle, Owings Mills, MD 21117							
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permit. Departi	ĺ	21. Signature of Funeral Service Lieensee Dorota Marshall 22. Name and Addre Marylar	nd Cremation Services							
	\dashv	23a. Short is the disease, or complications that caused the death. Do not enter the mode of dying a short of their failure. Life only one cause on each line.	ng, such as cardiac or respiratory arrest, Approximate meterval Between							
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To th withiu To th	Ň	29b. Signature and the of certifier Allen Mullaum 29c. Licens	se number 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year)							
{ v		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	Ploid Court Road							
Stat	e	31. Date filed (Month, Day, Year) 32. Registrar's Signature	Randalistown, marylar							
Registra	ar 🗐	JAN 19 2010 Seculo S. Janes	2 /133							
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ Month Leona L. Denton 2010 10:55A Jan Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Ivy Hall Nursing Home Baltimore Co. Middle River 8. Date of Birth
(Month, Day, Year)
7,1930 Social Security Number 6. Sex Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Days Hours 1 □ M 2 🗓 F Country)
Maryl Director Yrs. 212-28-9316 and Usual Residence of Decedent shov 10a. State 10b. County 10c. City, Town or Location iral", or items 23a or 28a-f sho Examiner must be notified at 10d. Inside City Limits Director **Dundalk** MD Baltimore 1 ☐ Yes 2🏋 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21222 7807 New Battle Grove Road United States 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Completed by 1 Never Married 2 Married within 72 hours after Maryland 21215-0036 1 ☐ Yes 2 💹 No Specify: "natural", Specify: 3X Widowed 4 □ Divorced White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker 6 Years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Thomas Mardaga Florence Kesterson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7807 New Battle Grove Road Dundalk, MD 21222 Kathy L. Hagy (Daughter) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 1/9/2010 4 ☐ Donation 5 ☐ Other (Specify) Oak Lawn Cemetery Baltimore, MD 21. Signature Funeral Service Licenses Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, 7922 Wise Dundalk. Ave 23a. Part 1. Enter the disease, o complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. Approximate Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Hospital or Attending Physician; The law requires that the death certificate be executed physician and strans resulting in death) Last Physician/Medical Box 68760 attending p IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death in the past 12 months? Month Pregnant at time of death ed by the a 2 No 9 Unknown P.O. been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ▶ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an s certificate has build linector, page 2 s autopsy performe death? 2 No Yes 2 25. Was case referred to predical Be 26. Place of Death (Check only one) examiner?

1 Yes ျ 2 No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 Residence 6 Other (Specify) 27. Man of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending work' within 24 hours after death.

To the Funeral Director: Af
completed filled in by the fu death. Investigation
6 Could not be 1 🗆 Yes 2 🗆 No Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. and title of certifier 29b. Signatur 29d. Date signed (Month, Day, Year)

State Registrar rar's Signature

ace Dundat MD 21222

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 17 & 18 per Fh. G902 4/20/10 TT State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** Karafillis Dikas PM 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Square osedale Homere tranklin Hospita Cente If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 NY Social Security Number 6. Sex 7. Age (In yrs. last birthdav) Date of Birth (Month, Day, **Funeral** Months Days Hours Min. 1 XM 2 □ F 34 10-4-1975 Director <u>058-70-2673</u> Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, It a Marical Examinar must be rectified at 1 ☐ Yes 2X No Director Baltimore MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21237 5212 Daybrook Circle 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Sikas, Karatillis altimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 ▼No Specify 2 Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) s 1 and 2 should be filed within of Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Food Service 2<u>+</u> Restaurant Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (Eirst, Middle, Maiden Surname) **Tsamhica Kountraki** Be Anargyros ပ Tsabika Frangakis Anaegyros Dikas 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joanna Dikas - Wife 5212 Daybrook Circle, Baltimore, MD 21237 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages 1 permit. Pages 1
Department of H
Important: If ite
any Injury or ot
once. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Oak Lawn Cemetery: 1-19-10 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Bradley-Ashton Funeral Home, 21. Signature of Funeral Service Licensee PA, 2134 Willow Spring Road, 21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** disease or condition resulting in death) Kight basal ganglia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Directo for as a consequence of Exami the attending physician and hed for use as the burial-tran Due to (or as a consequence of): Box 68760, death certificate be Physician/Medical nse 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 T Ectopic pregnancy for 1 in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) P.0. signed by the a be detached f □Yes 2□No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ð 2 No 3 Probably 4 Unknown 1 🗌 Yes page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 A No certificate 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? Hospital or Attending 5 ☐ Pending investigation 1 Natural death. 1 □Yes 2 □No 2 Accident within 24 hours after death To the Funeral Director: filled in by the 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number NGUYEN, mh DI 05094 BINH 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Binh Nguyen MO. 31. Date filed (Month, Day, Year) JAN 19 2010 1000 Franklin Drive Baltimore, MD 21237 82. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black inscribed Amend #12, per State of Maryland Department of Health and Mental Hygiene 2010 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death January 1 Physician/ 7.15A.M 2010 DANILLER HARRY Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** PIKESVILLE BALTIMORE ARDEN COURTS . Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) LATVIA 1 X M 2 - F Days 11/3/1927 215-28-8619 82 Yrs. Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland Director ms 23a or 28a-f s must be notified 1 Yes 2 No MD BALTIMORE PIKESVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21208 USA 8909 REISTERSTOWN ROAD Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

The Yes 2 No If Yes, Give Year or Dates. Black White etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced WHITE 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) RETAILER CLOTHING Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental F item 27 is marked o and Mental မ DANILLER EUGENE anna 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6234 WOODCREST DRIVE, ELLICOTT CITY, MD. 21043 ANITA GORDON / DAUGHTER 20b. Place of Disposition (Name of ANSHE FMINAH CEMETERY ATT CHAIM CEMETERY 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1
Department of
Important: If it
any injury or o 1 X Burial 2 Cremation 3 Removal from State 1/15/2010 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC 8900 REISTERSTOWN ROAD, PIKESVILLE, MD. 21. Signature of Funeral Service License 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Discone Onset and Death Immediate Cause (Final Cardiovas culm Physician/ Alter relevolue disease or condition resulting in death)) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if a ry, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Jue to for as a nonsequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Pregnant at time of death 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available 24a. Was an autopsy performed? prior to completion of cause of death?

1 Yes 2 No Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) 8 examiner? Other: 4 Nursing Home 5 Residence 1 ☐ Yes 2 ☐ No Certificate: To 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1-Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) 30 641 Januar 13 2010 Brick River Mech Road Balhome Maylandzizz 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ramesh Schapshir 201-108 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 19 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Department of Health and Mental Hygiene					
			Registrar Certificate of Death 1. Descriptive Name (First Middle ast)	2				
	Physicia Medic	cal	EDWARD B. EVANS BOTH 182 WITO 1331	М				
	Examin	er	4a. Facility Name (if not institution, give street and number) Anne Arundel Medical Center 4b. City, Town, or Location of Death Annapolis 4c. County of Death Anne Arundel					
	Funeral Director		5. Social Security Number 6. Sex 17. Age (In yrs. last birthday) 66 Yrs. 67 Yrs. 66 Yrs. 67 Yr	įn				
	nyland a-f show fied at	ctor	Usual Residence of Decedent 10a. State MD					
	ith the Me 23a or 28a st be notii	Funeral Director	10e. Street and Number 2500 Lesh Court 10f. Zip Code 21114 10g. Citizen of What Country? U.S.A.					
36	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hyglene, item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	þ	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 □ No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ Yes 2 □ No Specify: Spe					
21215-0036	nin 72 hours ne. ihan "natura e Medical E	Completed	15. Decedent's Education (Specify only highest grade completed) Filementary/Seconday (0-12) College (1-4 or 5+) College (1-4 or 5+)					
and 21	should be filed within and Mental Hygiene. 'is marked other tha raumatic event, the I	To Be C	8 Factory Worker Industrial 17. Father's Name (First, Middle, Last) Leroy Evans 18. Mother's Name (First, Middle, Maiden Surname) Catherine Hundt					
Maryland	ould by mark mark		Leroy Evans Catherine Hundt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)					
	and 2 sh Health ar tem 27 is other trau		Jennifer deFrees/Daughter 2500 Lesh Court, Crofton, MD 21114					
Baltimore,	Page nent o ant: If Iry or		20a. Method of Disposition 1 Burial 2 To Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Ardent Cremation Services 01/18/2010 Hanover, Maryland					
Balt	permit. Page Department Important: any injury o		21. Signature of Puneral Service Licenses 22. Name and Address of Facility Ardent Cremation Services 7522 Connelley Drive, Ste.N, Hanover, MD 21076	5				
	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition							
	Medical Examiner		resulting in death) Due to (or as a consequence of):	Ŧ				
	nted d ansit	Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury					
09	ate be executed oblysician and the burial-transit	edical Exa	that initiated events resulting in death) Last C. Due to (or as a consequence of):					
9289	tificate ng phy as the		IF FEMALE:					
Box	or Attending Physician: The law requires that the death certificate be executed streed that. Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months? 1	Ž				
ds, P.O.	w requires that the sound by sound be detailed		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1	vn				
Division of Vital Records,	sician: The law rec certificate has bee irector, page 2 sho	Completed by	24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No	Э				
ital	is certific director,	Be	25. Was case referred to medical examiner? 1 Ves 2 No Hospital: 1 Post tight 3 POA Other: 5 Projections 5 Projections 5 Post tight 5 Projections 5 Post tight 5 Projections 5 Post tight					
n of V	ding Phys h. After this funeral di	ate: To	27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury at work? 28d. Describe how injury occurred work?					
ivisio	al or Attending Physis s after death. Il Director: After this ced in by the funeral dire	Certificate:	Accident Investigation M 1 Yes 2 No					
	To the Hospital or Attendii within 24 hours after death. To the Funeral Director: Al completed filled in by the fu	Medical	29a. Certifier (Check Check Ch	ited.				
	To the withing company	-	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 29d. Date signed (Month, Day, Year)					
	V	ka Ar	30 Name and address of person who completed cause of death (Item 23a) (Type, Print) WICHTE J. LUIENA W 445 DEFENSE HIGHWAY ANN MUS MOZIYO	1				
	Sta Registra		31. Date filed (Month, Day, Year) 32. Registar's Signature JAN 19 2010 Lever A. barket					

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 00736 State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January 18, 201^{rga} Elliott 9:00 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Baltimore Towson Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 X F August 14, 1940 213-36-4733 Maryland **Director** 69 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County 10c. City, Town or Location be filed within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 Yes 2 No Maryland Baltimore Lansdowne 10e. Street and Number 10g. Citizen of What Country? Funeral 2800 Tennessee Avenue 21227 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Completed by 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 X Widowed 4 □ Divorced White Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I once. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Housewife years Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert C. Hyland Edith Radke 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph Elliott 5633 Harvey Court, White Marsh, Maryland 21162 son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State January **IANUARY** Bayview Crematory 1 Burial 2 XCremation 3 Removal from State 21, 2010 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signative of Funeral Service Licensee 22. Name and Address of Facility Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) AMYOTHROPHIC LATERAL SCLEROSIS Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): the Hospital or Attending Physician; The law requires that the death certificate be execute physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2**X** No
9 ☐ Unknown Month Day Year Pregnant at time of death Other (specify) is certificate has been signed by the director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? EDITH ELLIOT Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an After this certificate I Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 1 🗌 Yes 2 🗶 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6X Other (Specify) HOSPICE 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28c. Injury at work?
1 \(\square\) Yes 28b. Time of 28d. Describe how injury occurred 1 X Natural injury 5 Pending ☐ Accident ☐ Suicide 2 No Investigation within 24 hours after death

To the Funeral Director:
completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JENNIFER HAUF, CRNP 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

State of Maryland / Department of Health and Mental Hygiens Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** Mary F. Eberwein 14,2010 11:15P M January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Riverview Care Center Baltimore Essex If Under 24 Hrs. If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 □ M 2 🕱 F Director 9-13-1923 216-18-7113 86 Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 ☐ No Director MD Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? es 1 and 2 should be filed within 72 hours after death v of Health and Mental Hygiene.

Tithen 27 is marked other than "natural", or items 23a other traumatic event 2931 Yorkway 21222 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 þ 1 □Yes 2 □XNo Specify:White 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) æ ပ <u>John Frank Kolarik</u> Bertha Schultheis 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3611 Parkhurst Way, Nottingham, MD 212 go of Disposition (Name of Date 20c. Location - City or Town, State <u> Charles Eberwein - Son</u> MD 21236 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 1 □ Rurial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Parkwood Cemetery 1-18-10 Baltimore, MD 22. Name and Address of Facility Bradley-Ashton FUneral Home 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 2134 Willow Spring Road, 21222 Approximate Interval Between Onset and Death Immediate Cause (Final VASCULAR PERIPHERAL DISEASE Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or se a consequence of) Examir and burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Year Month 5 Other (specify) 9 Unknown After this certificate has been signed by funeral director, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 ☐Yes 2 ☐ No 1 ☐ Yes 2 HNO 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 1No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 ☐ Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No after death 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 29a. Certifier Medical 🔟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) D0060560 16,2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9106 PHICADELPHIA BALTIMORE MD KHETERPAL # 208 (Month, Day, Year)
JAN 19 2010 31. Date filed (Mo 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ J^{Month}ary Fifer, Sr. 2010 11:45 Ам Arthur Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Peartree Assisted Living Pasadena 6. Sex 1 X M 2 □ F If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Y Months Days Hours Maryland Director 919 577**–**16–2265 90 Oct. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland Director 10d. Inside City Limits "natural", or items 23a or 28a-f s edical Examiner must be notified 1 Yes 2 No Millersville Marvland Anne Arundel 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21108 1147 Cecil Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: If Yes, Give 3 ₩ Widowed 4 Divorced Year or Dates White Page 1 and 2 should be filed within 72 hours ment of Health and Mental Hygiene. ant: If item 27 is marked other than "hatur ury or other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Seafood Company <u>Owner</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Hartge Mary Louise 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1147 Cecil Avenue Millersville, Maryland 21108 Arthur E. Fifer, Jr. (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1 a
Department of I
Important: If ite
any injury or ot 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery 01/20/10 Brooklyn Park, Maryland 21. Signature of Furreral Service Licensee 22. Name and Address of Facility
McCully-Polyniak Funeral Home P.A.
3204 Mountain Road Pasadena, Maryland 21122 23a. Part 1. Enter the disease, or complications that or used the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Inset and Deat Physician/ disease or condition resulting in death) 90 Medical Due to lor as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed for use as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): יי שודים שונים או עו שונים שונים או certificate has been signed by the attending physician completed filled in by the funeral director, page 2 should be detached for use as the hurral Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 3 11 1 Yes 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 12000 မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural injury work? 5 Pending 2 🗌 No 2 Accident
3 Suicide Investigation 24 hours after deat Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 🚅 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: Jo the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one) 29d. Date signed (Month.

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 00739 State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Franklin 2010 Eugene Leroy J<u>anuary</u> 9:52A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Timonium Baltimore Stella Maris Social Security Numbe 6. Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) 9/16/194 1 🛛 M 2 🗆 F Months Days Hours 219-38-7753 **Director** 68 Usual Residence of Decedent show 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Baltimore 1 X Yes 2 No MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21224 U.S.A. 3 North Kenwood Avenue 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 X Yes 2 ☐ No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Police Officer Law Enforcement Be 17. Father's Name (First, Middle, Last) Unknown 18. Mother's Name (First, Middle, Maiden Surname) Doris Franklin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) North Kenwood Avenue, Baltimore, MD 21224 Lynne Franklin / Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Anatomy Gifts Registry 4 X Donation 5 Other (Specify) 1/18/2010 Hanover, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Anatomy Gifts Registry 1 7522 Connelley Drive, Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) a. HEAD AND NECK CANCER Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate care Externocraping Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): nding physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Yes 2X No 1 ☐ Yes 2 🔀 No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 1 ☐ Yes 2X No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of within 24 hours after death.

To the Funeral Director: After t completed filled in by the funera 28c. Injury at 28d. Describe how injury occurred 1X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 K Certifying Nurse Practice or To the Sout of my knowledge. Seath occurred at the time, date and place and Seath occurred at the time date and place and Seath occurred at the time date and place. 29a. Certifier (Check 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 230Q DULANEY VALLEY RD. JACKIE JONES. CRNP TIMONIUM, MD 21093

State Registrar

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2010

ANUARY

EUGENE FRANKLIN

istrar's Signature

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	To the comp	2	29b. Signature and title o	of certifier	7/)	1		29c. License DOO					signed (Mont	_		`
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	/ /		30. Name and address of													
	Stat	е	Paul Tham 31. Date filed (Month, Day	bi, MD,	9707 Med 32. Resistrar	ical 's Signatu	Center	r Drive,	Ste	.300,	Rockvi	lle,	MD 208	850		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2010 1 = For State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** SCAR 17:00 M Januar 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner **Baltimore City** The Johns Hopkins Hospital If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 10/19/1956 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1**X** M 2 □ F 53 Maryland 219-68-8524 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10c. City, Town or Location 10d. Inside City Limits MD Howard Jessup 1 XYes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code 20794 U.S.A. 8738 Rose Lane Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married 2 🔀 No 1 Yes 2 No Specify White Specify þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Construction Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mary Tumblin Edgar Allen Fincham 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8738 Rose Lane, Jessup, MD Mary Aretta Fincham/Mother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☆ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ardent Cremation Services 01/19/2010 | Hanover, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ardent Cremation Services 7522 Connelley Drive, Ste.N, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused t shock, or heart failure. List only one cause on each line or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CARLODUMORAS arrest /Medical Due to (or as a consequence of): **Examiner** Subarachn Service finite list on willing Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death Pregnant at time of death 3 Ectopic pregnancy Month Year in the past 12 months? Day 5 Other (specify) 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ **4**₩ Unknown 1 🗌 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 28a. Date of Injury (Month, Day Year) 28b. Time of Injury at Work? Manner of Death 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation Injury 1 Tes 2 No 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) þ 4 - Homicide determined

or Attending Physician: The law requires that the death certificate be executed physician an Division of Vital Records, P.O. Box 68760, attending p ate has page 2 this s after death. within 24 hours a

To the Funeral C

completely filled Hospital

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Baltimore, Maryland 21215-0036

Certification: To 29a. Certifier **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 | Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Queshi

January 17, 2010 BES 000 600 North Wolfe St, Baltimore, MD, 21287

29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year,

Abid

29b. Signature and title of certif

and manner stated

			For State of	Maryland / De	•		Mental Hyg	iene	20710	
			Registrar 1. Decedent's Name (First, Middle, Last)		Certificate of L	Death	2. Date of Deat	leg. No. 2	1,00742	
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920	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show with injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced 12. Was Decede Armed Force 1 □ Yes 2 If Yes, Give Year or Date	es? LXNo	13. Was Decedent of HIf Yes, specify Cuba1 ☐ Yes 2 X No	an, Mexican, Puert	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, Whit Specify: Wh	e, etc.	
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Maryland	2 should be file th and Mental F 27 is marked o traumatic eve		19a. Informant's Name/Relationship (Type, Print) Donna Doyle Daughte		Mailing Address (Street Box 518,	and Number or Ru	ral Route Number,		o Code)	
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Baltimore,	. Page tment o tant: If jury or		1 ☐ Burial 2 XCremation 3 ☐ Removal from St 4 ☐ Donation 5 ☐ Other (Specify)		crematory or other place w Crematory		2010	Baltimore,	Maryland	
Ball	permit. Page Department Important: I any injury o		21. Signature of Fruneral Service Licensee	nelly	7110 Solle	ers Point	: Road, D	undalk,P.A undalk,Md.	21222	
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. Box 68760	the Hospital or Attending Physician: The law requires that the death certificate be executed that A hours after death. The Attendent Birector, After this certificate has been signed by the attending physician and mpleted filled in by the funeral director, page 2 should be detached for use as the burial-transition.	Completed by Physician/M		th 2 L Fetal death nt at time of death	3	у		23d. Date of delivery Month Day Year		
s, P.O.	ires that the des signed by the s d be detached i	d by Pł	Part II. Other significant conditions contributing to dear	th but not resulting in the	he underlying cause giv	ven in Part I.		pacco use contribute to	the cause of death?	
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J of	ling Phys .r After this funeral di		27. Manner of Death 1 Natural 5 Pending 28a. Date of (Month,		e of 28c. Injury	y at	28d. Describe ho	, , ,	<i></i>	
Division	To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director, After this completed filled in by the funeral direction and the funeral direction.	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place of building.	Injury - At home, farm, , etc. (Specify)		Yes 2 No	28f. Location (Str City or Town	reet and Number or Rural Route Number, , State)		
Ω	Hospital 24 hours : Funeral I	Medical	29a. Certifier 1 Certifying Physician: To the bes 2 Medical Examiner: On the basis	of examination and/or in	rvestigation, in my opinio	on, death occurred	at the time, date and	d place, and due to the	cause(s) and manner stated.	
	To the within To the Comple	Σ	only one) 3 ☐ Certifying Nurse Practioner: To 29b. Signature and title of certifier	The best of my knowledge	29c. License	number	25	9d. Date signed (Monti	n, Day, Year)	
)		20 Nome and others 16	and in	100	2005		lte. Md	18,2010	
	12		30. Name and address of person who completed cause of the A. R. Ley C. B.M.	nc 670	/ N. C	horles.	St. Ba	etr. Md	21204	
	Stat Registra		31. Date filed (Month, Day, Year) 32. Regi	istrar's Signature	2					

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** <u>Geraldine E. Flester</u> 13,2010 /Medical January 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Heritage Nursing Home Dundalk Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12-23-1923 9. Birthplace (State or Foreign Country) FL Months **Funeral** Min. Davs 1 □ M 2 🛛 F Hours 216-18-6926 Yrs. 86 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, its Medical Exprinter mast be notified as once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Baltimore Dundalk 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Center Place, 101 Apt. 21222 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: White δ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 Domestic Housekeeper Housekeeping 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Unknown Flester ပ Margaret Ginneman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daughter Bonmot Pl., 12292 Reisterstown, MD 21136 Beverly Flester in law 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Bayview Crematory 1-18-10 Baltimore MD 21. Sign by of Funeral Service Licensee Bradley-Ashton Funeral Home 2134 Willow Spring Road, 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between CARDIONASCUARDISEASE Immediate Cause (Final disease or condition resulting in death) RO **Physician** /Medical ERTENSION Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregn 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 □ Yes signed by the a 9 Unknown significant conditions contributing to death but not regulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an cate has I page 2 s 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mann f Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: 1 atural 5 Pending investigation 1 ☐ Yes 2 | No neral Director; / filled in by the f 2 Accident 3 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours 29a. Certifier 🔁 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar 31. Date filed (Month, Day, Yea JAN 1, 9

Year)

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DHMH 17 Rev 1/2001

ausejoi bleath (Item 23a) (Type Prior)

22. Registrar's Signature

ymond Greer	1	1- For State	e of Maryland		artment of rtificate of		nd Men	tal Hygi		201	0 00744	
Physici		1. Decedent's Name (First, Middle,La					•		Date of Deat		3. Time of Death	
edical Exami	ner	Raymond Edwar		.)		4b. City, Town, o		J	anuary 8,	2010	2309 hrs	
		4a. Facility Name (if not institution, g Mercy Hospital	give street and number	r)	T '	Baltimore	or Location o	or Death		4c. County of D		
Funeral		5. Social Security Number 6.	Sex 7. A	ge (In yrs.	last birthday)	If Under 1 Ye		er 24Hrs. 8.	Date of Birt	h(MM/DD/YYYY) 9.	Birthplace (State or	
Director		218-78-9949	X M 2□F	50	Yrs	Months Da	ys Hours	Min. S	ept.	14,1959	oreign Maryland Country)	
Α.		Usual Residence of Decedent 10a. State 10b. County		Ian- Cit	, Town or Locat						10d. Inside City Limits	
T 00% an		N/A	A	Toc. City	Balti	more					1 X Yes 2 No	
aryland 8a-f sh at onc	Director	Maryland 10e, Street and Number				10f. Zip Code			10	ng. Citizen of What (Country?	
ith the Maryland 23a or 28a-f show any notified at once.	Dire	2925 Ellicott	: Drivewa	ıy		2121	6			USA		
h with	uneral	11. Marital Status	12. Was Deceder			s Decedent of H es, specify Cuba				14. Race - Ar White, et	merican Indian, Black,	
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urs afte tural"	d by	15. Decedent's Education (Specify	or Dates:	mpleted)		Yes 2 X N		kind of work	done	Specify: 16b. Kind of Business/Industry		
5 72 hoi n "na sal Ex	Completed	Elementary/Secondary (0-12)	College (1-4 or	5+)		ost of working lif	fe. DO NOT	use retired)		Drivate	Industry	
within jene.	omo		1 year	_	Lai	orer						
15-(filed al Hyg red oth	e C	17. Father's Name (First, Middle, Las Raymond T. G.	•				Lavi	s Name (Fir nia	st, Middle, M Batts	faiden Surname)		
212 ould be d Ment s mark	To B	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailing	Address (Stre	eet and Num	ber or Rural	Route Num	ber City or Town, S Baltime	tate Zip Code) 2123	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Montal Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		Donna Murray	/ Sister	Loo	1001	pbrin	J					
Ore, ges lau of Hea If ite		20a. Method of Disposition 1 Burial 2 Cremation 3	Removal from S	tate	Place of Dispos crematory or oth	ner place)		Da 1 / 1		20c. Location - City	lk, Maryland	
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Ba perm Depa Impe		To and Ha	I AC		5	240 Re	iste	cwtow	man-F n Rd	Baltimo	uneral Home re,MD 21215	
Physician		23a. Art I. Enter the disease, or comailure. List only one cause on		d the death							Approximate Interval Between Onset and	
/Medical Examiner			a. Pulmonary Th			e to deep	leg vein	thromb	osis		Death	
′			Due to (or as a cons	sequence o	or):						=	
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a cons	equence o	of):							
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Division of Vital Records, P.O. Box 68760, Hospital or attending Physician: The law requires that the death certificate be executed 24 hours after death. Funeral Director: After this certificate has been signed by the attending physician and rely filled in by the funeral director, page 2 should be detached for use as the burial - transit	alE	d.										
O, e be ex ysician burial	edical	UNPENDED	AMENDED							Tan in a sur		
Box 68760, death certificate be attending physical for use as the but	sician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outco	me of preg		al death 3	Ectopic	pregnancy		23d. Date of deli Month	very Day Year	
OX 6	sici	1 Yes 2 No 9 Unknow	'	t time of de	time of death 5 Other (Specify)							
D. B t the de by the	Phy	Part II. Other significant conditions		th but not r	esulting in the u	nderlying cause	given in Pa	rt I.	23e. Did tot	bacco use contribute	e to the cause of death?	
ires that to signed by the detac	d by								1 Yes	2 🗸 No 3 🗌 F	Probably 4 Unknown	
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of Vital Records, og Physician: The law requiranter this certificate has been sineral director, page 2 should be	욘	1 ✓ Yes 2 No 27. Manner of Death	28a. Date of Inj		ER/Outpatient 28b. Time of Ir		Other ₄	Nursing Ho		Residence 6 O	ther:	
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Division [12] or Attendir 13 after death. 24 Director: A led in by the fu	ertification:	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural R									Rural Route Number, City	
Division Hospital or Attence 24 hours after death Funeral Director:	Cert	4 Homicide determin							or Town, St	ate)		
	I	(Circuit Circy)	cian: To the best of mer:On the basis of exa		-							
To the within 2 To the complete	Medica	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cand manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month										
		Compite Il	re Uhill			O.C	M.E.			January 9, 20		
1 /		30. Name and address of person who	completed cause of	death (Item	,							
\ \ \			Assistant Medical			enn Street, E	Baltimore	, MD 212	01			
St Regist	ate	31 Date filed (Month, Day, Year)		ar's Signati	ba	23						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 00745 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ January Anne Gregory 2010 2:50 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Baltimore Towson 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 87 yrs. If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign New Jersey 153-16-1956 1 🗆 M 2 💢 F Months Hours Min. 4/8/1922 Year) Director Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 23a or 28a-f sho important: If item 27 is marked outher than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Tov City, Town or Location 10d. Inside City Limits Director Baltimore MD 1 🗆 Yes 2 📈 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 543 Piccadilly Road USA 21204 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian Armed Forces Black, White, etc. ð 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: Completed 3 X Widowed 4 Divorced Year or Dates. WW I I 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (54 or 5+) Church Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ James Joseph Cox Emma Polifka 19a. Informant's Name/Relationship (Type, Print)
Joanne Mary Gregory 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 543 Piccadilly Road Towson, Maryland 21204 / Dtr 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 1/18/2010 Timonium, Maryland 4 Donation 5 Other (Specify) Dulaney Valley Mem. . Signature of Funeral Service Licens 22. Name and Address of Facility Towson, Maryland 21204 Ruck Towson Funeral Home, Inc. 1050 York Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Immediate Cause (Final Onset and Death Physician/ Complications disease or condition resulting in death) Medical Examiner Due to (or as a consequence of) Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Pregnant at time of death 5 Other (specify) Day Year 1 ☐ Yes ∠ ¥ 9 ☐ Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of death?

1 Yes 2 No Ves 2 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 X No 은 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Nother (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending injury work? 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Secretifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) R149194 January 15,2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) havion Grant 6701 Charles MD 21204 31. Date filed (Month, Day, Year) . State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND ITEM#30, perDVR, G899, 1/1972010, WS State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav Year **Physician** 18 2010 1:00 A Peggy Stephanie Hodges January /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Manor Care Chevy Chase If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year) Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🖼 F 114-28-1825 76 New York Director 12/26/1933 Usual Residence of Decedent death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2X No Director DC Washington 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 4201 Butterworth Place N.W. 20016 U.S.A. Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2**X** No Specify. White Specify: ģ 3 ☐ Widowed 4 ☑ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 4 Librarian Education 18. Mother's Name (First, Middle, Maiden Surname) Unknown 17. Father's Name (First, Middle, Last) Unknown Be 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sheldon Martin / Friend 4201 Butterworth Place #301, Washington, DC 20016 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Anatomy Gifts Registry 1/18/2010 Hanover, Maryland 4X Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Anatomy Gifts Registry 21. Signature of Juneral Service Licensee 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CERVICAL CANCER hysician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending pt for use as t 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 5 Other (specify) signed by the a Id be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ➡ No 24a. Was an has page 2: autopsy performed? Yes 2210o this certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Surring Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🙀 Ño 2 27. Manner of Death 1 ₩ Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Ecritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certified

State Registrar Truong

Bao 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

0005

Montgomery Medical Associates 10110 Molecular Dr. Rockville, MD 20850

1118/10

Ser, mo

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND ITEM# 25perME, G905, 7/2272010, WS
State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Edward R. Huneke, Jr. 5:52 2010 January 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Baltimore Greater Baltimore Medical Center Towson 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Jan. 22, 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 1X M 2 ☐ F Months Days Hours 215-28-0189 Maryland 1932 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County MD Baltimore Parkville 1 ☐ Yes 2 XNo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21234 U.S.A. 2412 Bradford Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2K Married 1 □Yes 21XNo White Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Insurance College (1-4or 5+) Insurance Underwritter 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edward Richard Huneke, Sr. Jennie Marie Bish 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2412 Bradford Road, Parkville, Maryland 21234 Patricia Huneke/ Wife 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of Moretal Park Memorial Park Date 20c. Location - City or Town, State 01/18/10 Parkville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Jart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Im ediate Cause (Final ase or condition sulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) CENTRICATION APPROVED BY MEDICAL EXAMPLER Due to (or as a consequence of) IF FFMALE yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

PULMUMLY EMBOLISM 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \(\text{(Specify)} \) 1 X Yes 2 Yes 1 Xinpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending Injury 1 □ Yes 2 □ No 2 Accident investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number mpleted cause of death (Item 23a) (Type, Print)

Physician: The law requires that the death certificate be executed Box 68760, o ۵ Division of Vital Records, To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral

> State Registrar

Physician

/Medical

Examiner

Funeral

Director

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Director

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Medical Certification: To

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 shov any injury or other traumatic event, If a Medical Examination to the returnation.

Physician /Medical **Examiner**

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar 00748 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Hamner 1:20 2010 Jan Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Maryland Medical Center N/A of University Baltimore 5. Social Security Number . Sex 14∆ M 2 □ F . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 0ct. 4, Year) 972 271-86-1648 Months Days Hours Min. Country) Ohio **Director** Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD 1 Yes 2 No Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 704 Kraft Court 21061 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? Black, White, etc. 1 Never Married 2 XMarried 1 Yes 2 ☐ No If Yes, Give Completed by Baltimore, Maryland 21215-0036 Specify: Black 1 Yes 2 No Specify: 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (3-4 or 5+) Systems Analyst U.S. Army Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Hamner Mae Brand 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs Rhida Vazquez / Wife 704 Kraft Court Glen Burnie, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) January Maryland Vets. Cem. 4 Donation 5 Other (Specify) 25,2010 Crownsville, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Singleton Funeral & Cremation Services PA 1 2nd Ave. SW Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Sepsis-related cardiomy opathu disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Neutropenic sepsis Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Exami the Hospital or Attending Physician: The law requires that the death certificate be executed Cutareous T-cell lymphoma and burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last the attending physician the derivative the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Live Birth 2 Live Birth 2 Pregnant at time of death Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month detached 9 Unknown g 🗌 Unknown cate has been signed by page 2 should be detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed' death? this certificate 1 ☐ Yes 2 No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No မ 1 Npatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After (Month, Day, Year) Natural 5 Pending work' 1 🗌 Yes 2 🗌 No ☐ Accident Investigation the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. pleted Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

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State

22 South Green Street

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Bashmore, MD 21201

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2010

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32.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

JAN 19

10-00488 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Carl Vaughn Haislett 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day January 17, 2010 **Medical Examiner** Carl Vaughn Haislett 1843 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 2953 Yorkway Dundalk **Baltimore County** 5. Social Security Number 6. Sex 7. Age (In yrs, last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Hours Director April 14,1960 Country) Maryland 217-80-0605 1XM 2F 49 Yrs Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d, Inside City Limits any. 1 Yes 2 XNo Maryland Baltimore Dundalk imore, MD 21215-0036

Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental Hygiene.
nant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2953 Yorkway 21222 USA Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, other than "natural", or items the Medical Examiner must be Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 Married 2 X No Yes f Yes, Give Year or Dates: 4 Divorced Specify: White 3 Widowed 1 Yes 2 X No specify: ģ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 9 years Mechanic Shop Foreman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Sidney B. Haislett Gertrude R. Bauer 19a. Informant's Name/Relationship (Type, Print) 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maria Haislett Friend 1957 Sue Creek Drive, Essex, Maryland 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Date 20c. Location - City or Town, State timore, crematory or other place) 1 Burial 2 Cremation 3 Removal from State January Department o Sacred Heart of Jesus Cem. Dundalk, Maryland 22, 2010 Donation 5 Other Specify: Signature of Funeral Service License Connelly Fuheral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 23a. Part I. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and **Physician** failure. List only one cause on each line. /Medical a. Ruptured myocardial infarct due atherosclerotic cardiovascular disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as e consequence of): events resulting in death) Last ned by the attending physician and detached for use as the burial - transi sician/Medical AMENDED UNPENDED of Vital Records, P.O. Box 68760, 23d. Date of delivery IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify, 1 Yes 2 No 9 Unknown Unknown Phy Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed t þ 1 Yes 2 ✔ No 3 Probably 4 Unknown Completed page 2 should has been 24a, Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed' death? certificate Yes 2 No 2 No 1 🗸 Yes director. To the Hospital or Attending Physician: within 24 hours after death. 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 Other Nursing Home 5 Residence 6 Other: Scene ER/Outpatient 3 DOA this 1 🗸 Yes ဥ 2 No 28a. Date of Injury (Month, Day, Year After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 V Natural Division 5 Pending 1 Yes 2 No the within 24 hours after death To the Funeral Director: 2 📋 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. January 18, 2010 30. Name and address of person who completed cause of death (Item 23a) Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32. Registrar Signat State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ JANUARY 2010 EDWIN **HECKER** 12:30P ^M Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** NORTH OAKS HEALTH CENTER PIKESVILLE BALTIMORE Social Security Number 6. Sex. 1 🛣 M 2 □ F If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country)
 NY 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** Days 96 0671171913 219-42-6241 Director Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 💢 No BALTIMORE PIKESVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 725 MT. WILSON LANE 21208 12. Was Decedent Ever in U.S. Armed Forces (7 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed 3 Widowed 4 Divorced WHITE Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ **ATTORNEY** SOCIAL SECURITY Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ **HECKER** MORRIS FANNY SIEGEL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DANIEL HECKER / SON 3635 ORDWAY ST., N.W., WASHINGTON, DC 20016 20a. Method of Disposition 20b. Place of Disposition (Name of 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/17/2010 BALTIMORE, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 21. Sign ture of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Ph sician/ Dus / hagia Due to (+ s a consequence of): Medical resulting in death) Éxaminer Demensia Vascular Sequentially list conditions, if any leadin, to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Exami that the death certificate be executed Due to (or as a consequence of): attending physician for use as the buria Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ Division of Vital Records, or Attending Physician: The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed' death? 2 🗌 No 2 No Yes 25. Was case referred to medical B 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🔽 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No s after death.

I Director: Aft
d in by the fur 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined within 24 hours a

To the Funeral C

completed filled i Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Karen Balitt M.D.

Babitt

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4000 old

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court pad stife 301 Baltmore MD

29d, Date signed (Month, Day, Year)

January 15, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible State of Maryland / Department of Health and Mental Hygiene -Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** DERICK ONES 01 3 2010 /Medical 4a. Facility Name (If not institution, give street and number) County of Death Location of Dea 4c. Examiner If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Age (În yrs. last birthday) **Funeral** Min. 1 **3** M 2 □ F Months Days Hours 7-30-Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10b. County 10a. State 10c. City. Town or Location 10d. Inside Çity Limits s 23a or 28a-f show ust be notified at 1 res 2 No Completed by Funeral Director TIMOR 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 0 12. Was Decedent Ever in U.S.
Armed orces?
1 Dres 2 No
If Yes, Give
Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) th and Mental Hygiene.
7 is marked other than "natural", or items traumatic event, the include Examination. 11. Marital Status 14. Race - American Indian 1 Newer Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) ShOREMAN Be (17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٩ 0 Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) int of Health a t: If item 27 is or other train 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition Date - City or Town, State 1 Burial 2 ☐ Cremation 3 Removal from Department of Important: If any injury or once. 4 Domation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that cau ed the death. Do not enter the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Ŝ Sequentially list conditions, Physician/Medical Examiner cause. Enter Underlying Cause (Disease or injury that initiated events Lise to (or es a nonstiquienne of) The law requires that the death certificate be executed physician and the burial-trans resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, attending p use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) been signed by the should be detached 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ √ Inknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has by page 2 s autopsy performed After this certificate 1 ☐ Yes 2 🖵 No 1 ☐ Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2 (Ko 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Mann of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 🗆 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 retifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Year 55 PM **Physician** George Jacobs ILL 201C /Medical 4a. Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Randallstown Northwest Hospital If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign Country) Maryland 7. Age (In yrs. last birthday) 5. Social Security Number Date of Birth Funeral 213-34-3371 70 7/13/1939 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examined must be mortified at once. 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 1 ☐ Yes 2 X No Funeral Director Howard Elkridge Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 21075 6601 Pirch Way 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 YNo 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 I 1 ☐ Never Married 2 📆 Married White 1 ☐ Yes 2 X No Specify: Baltimore, Maryland 21215-0036 Be Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use relierd)
Wharehouse Worker/ Driver 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Funeral 10 17. Father's Name (First, Middle, Last)
George Lewis Jacobs 18. Mother's Name (First, Middle, Maiden Surname) Edna Delphine Allen ٥ 19b. Mailing Address *(Street and Number or Rural Route Number, City or Town, State, Zip Code)* 6601 Pirch Way,Elkridge,Maryland,21075 19a. Informant's Name/Relationship (Type. Print)
Cherry Jacobs/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place)
Atlantic Crematory 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/18/2010 Glen Burnie, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gary L. Kaufman Funeral Home, Inc. 7250 Washington BLvd., Elkridge, Maryland, 21075 23a. Part 1. Enter the disease, or compile ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final (Amyotrophic lateral Scherosis **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Day to for as a consequence of Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and nding physician and se as the burial-transi Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year 5 Other (specify) □Yes 2□No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 ☐Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□Yes 2□No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Mann of Death 28h Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 🗌 No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State Registrar

Medical

31. Date filed (Month, Day, Year)

S. Rajapakse

29b. Signature and title of certifier/

29a, Certifier

2835 32. Registrar's Signature

and manner stated.

DORSE M.D

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

150057465

Smith Av, S-203, Baltimore, MO, 21209.

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2010 Year Physician/ January 9:40 рМ **GEORGE** Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Rosa Anne Arundel Villa Nursing Home Mitchellville If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day Year) Jan. 1, 1922 9. Birthplace (State or Foreign Country) MaryLand 5. Social Security Number . Sex 1 **⊠** M 2 □ 7. Age (In vrs. last birthday Funeral Hours Months Director 214-12-0693 88 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Director Pasadena 1 Tes 2 X No Maryland Anne Arundel 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21122 U.S.A. 990 Beachwood Avenue Page 1 and 2 should be filed within 72 hours after death went of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status Armed Forces' þ 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify Specify: If Yes, Give Completed 3 X Widowed 4 Divorced Year or Dates 16a Decedent's Usual Occupation 15 Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Ft. McHenry Naval Reserve Elementary/Seconday (0-12) Stationary Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ൧ Evelyn Weitzell George Sutherlin Kirby Sr. other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 990 Beachwood Avenue, Pasadena, Maryland 21122 Joyce C. Malkinski (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of h Important: If ite any injury or ot 1 🔀 Burial 2 🗌 Cremation 3 🔲 Removal from State Jan. 18,2010 Glen Haven Mem. Park Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) permit. 21. Signature of Fu Service Licens 22. Name and Address of Facility 22. Name and Address of Facility McCully—Polyniak Funeral Home P.A. 237 East Patapsco Avenue, Bbaltimore, Maryland 21225 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one vause on each line. Approximate Interval Between Onset and Death mnediate Cause (Final Physician WEOG disease or condition resulting in death) en lears Medical Due to (or as a cons suence of): Examiner otemi Sequentially list conditions. Due to for as a consequence of cause. Enter Underlying Cause (Disease or iinjury been signed by the attending physician and should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 Pregnant Pregnant at time of death 1 L Yes 2 L 9 L Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has funeral director, page 2 autopsy performed? 2 No 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 X No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury work? 1 ☐ Yes 2 ☐ No Natural 5 Pending Accident
Suicide Investigation after death completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Funeral L Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 2 To the F only one) 3 🕽 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 7/2009

31. Date filed (Month, Day, Year)

(Item 23a) (Type, Print)

R068485

Bowie MD 20715

-15-10

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 10-00145 State of Maryland / Department of Health and Mental Hygiene 2010 Rosanna Beth Kroll 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ 1355 hrs Rosanna Beth Kroll January 5, 2010 Medical Examiner 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Halethorpe **Baltimore County** 307 4th Avenue If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) If Under 1 Year 5. Social Security Number 6. Sex **Funeral** Davs Hours Min. Dec. 5, 1949 214-56-0048 Months 60 Director Country) PA Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County Lansdowne 1 Yes 2 No MD Baltimore or 28a-f show or items 23a or 28a-f shor must be notified at once. death with the Maryland Director 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number United States 21227 307 4th Avenue Funeral 14. Race - American Indian, Black, 11. Marital Status 12 Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Never Married 2 Married Yes 2 White Pages I and 2 should be filed within 72 hours after of ment of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", oor other traumatic event, the Medical Examiner.n 1 Yes 2 No specify: Specify: If Yes, Give Year 4 Divorced 2 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Department of the 8 Biologist 12 Environment 18 Mother's Name (First, Middle, Maiden Surname 17. Father's Name (First, Middle, Last) Be Eugene W. Kroll, Sr. Betty Louise Light 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ဥ 2 Glenwood Rd., Apt B, Essex, MD 21221 Eugene W. Kroll, Jr. Brother 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Glen Haven Memorial 1-11-2010 Brooklyn Park, MD Donation 5 Other Specify: 22 Name and Address of Facility Ambrose Funeral Home, Signature of Funeral Service 2719 Hammonds Fry Rd., Lansdowne, MD 21227 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line /Medical Death a Atherosclerotic Cardiovascular Disease Complicated By Hypothermia Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and The law requires that the death certificate be executed Physician/Medical UNPENDED AMENDED Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 ✔ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o ģ 1 Yes 2 No 3 Probably 4 Unknown σ. Schizophrenia Completed Records, 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed? ✓ Yes 2 No 1 🗸 Yes 2 No After this certificate 26 Place of Death (Check only one) 25. Was case referred to medical Hospital or Attending Physician: Be Division of Vital Other Nursing Home 5 Residence 6 Other Scene Hospital: 1 Inpatient 2 DOA ER/Outpatient 3 1 Yes 28a. Date of Injury FOUND: 28d Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death Subject exposed to environmental cold FOUND: Natural 1 Yes 2 ✔ No Pending within 24 hours after death. To the Funeral Director: Director: d in by the f Jan 5, 2010 1355 hrs 2 🗸 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc Suicide Could not be or Town, State) 307 4th Avenue, Halethorpe, MD determined (Specify) Single Family Homicide 29a. Certifier 1 (Check only one) 2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

State Registrar 29b. Signature and title of certifier

Donna M. Vincenti, MD 31. Date filed (MJAN 1°9) 2

Assistant Medical Examiner

and manner stated

- 1m

OCVIE

30. Name and address of person who completed cause of death (Item 23a)

29d. Date signed (Month, Day, Year)

January 6, 2010

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black-Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month Day Physician 159 M Kromat 13 ì 2010 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Randallstown Baltimore Hospital orthwest If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, 9. Birthplace (State or Foreign Country) Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 1**X**M 2□ F 67 Yrs. 214-59-8832 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show in than "natural", or items 23a or 28a-f short the Medical Examiner must be notified at ykes ville Carroll 1 Yes 2 No Director MD10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 784 6009 Liberia Funeral 14. Race - American Indian, 12, Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 MNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2 No Specify. Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Waste Management Technician 18. Mother's Name (First, Middle, Maiden Surnam Jabaten 17. Father Name (First, Middle, Last) Be Kromah Vlama 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Margaret S. Kromah (Sister-in-law) Sykesville, 6009 Kennard Ct. MO. 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State 20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Removal from State 1-17-2010 Randallstown King Memorial Parle 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funaral Service Licensee Vaughn C. Greene Funeral Service 'own 8128 Liberty Rd M01401 en 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardlac or respiratory arrest, by ck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Atheroscierotic Cardiovascular /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner Day to for as a pursuous off cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last s been signed by the attending physician and should be detached for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

 1 ☐ Yes
 2 ☐ No 24a, Was an r this certificate has I ral director, page 2 s autopsy performe 1 ☐ Yes 2 MNo the Hospital or Attending Physician: 25. Was case referre to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Dother (Specify) Hospital: 1 Yes 2 No 1 Xinpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manual of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)determined 4 Homicide within 24 hours a 29a. Certifier 1 Detrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 00057465 1/14/10 11SKyapahse M.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, MD. 21209 N.S. Rajapakse, M.D. 2835 Smith AV, 203 Suite 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

Amend #2 & 31 per DVR 2899 1/19/10 TT
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Jan . 14 , 2010 3. Time of Death Month Day Year 1. Decedent's Name (First, Middle, Last) Physician Day 6:05PM KUNIN /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner HOSPI RANDALL STOWN BALTIMORE If I Inder 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Hours Min. Months 1 □ M 2 🔽 F Davs 86 215-45-5237 Director 04/13/1923 UKRAINE Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show ed other than "natural", or items 23a or 28a-f show event, the Medical Exactions must be retified at Director 1 ☐ Yes 2 X No MD BALTIMORE BALTIMORE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1450 BEDFORD AVENUE, APT. 617 by Funeral 21208 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) **PROFESSOR** h and Mental Hygie EDUCATION 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ould be f Mental I permit. Pages 1 and 2 should be Department of Health and Menta Important; If item 27 Is marked any injury or other traumatic ev CHAIM KINZBURSKI ပ MEITA KINZBURSKAYA 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>VIKTOR</u> KUNIN/HUSBAND 1450 BEDFORD AVENUE, APT. 617 BALTIMORE, MD21208 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ARETNETON CEMETERY CHIZUK AMUNO MXBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) BALTIMORE, MD 01/17/2010 22. Name and Address of Facility SOL LEVINSON & BROS., INC. f Funeral Service Li 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 Part1. Enter the disease, or complicate shock, or heart failure. List only one to hs that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest use on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician cespiratom disease or condition resulting in death) /Medical Due to (or a a consequence of). Examiner Stage Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the Hospital or Attending Physician: The law requires that the death certificate be executed P31'S and Due to (or as a consequence of). attending physician for use as the burla Box 68760 Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death
☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Day 5 Other (specify) Division of Vital Records, P.O. 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 s autopsy performed certificate 1 ☐ Yes 2 DNo 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Dipatient Medical Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0066 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Northwest Hospital Baltimore, MD 31. Date filed (Month. State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 14, 2010 7:40 p. M Israe1 Lerner Albert. January /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Silver Spring Holy Cross Hospital 9. Birthplace (State or Foreign Country) New York If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Jan 24, 1917 Director 086-10-2634 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural" --- any injury or other traumatic execution. 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a State 1 ☐Yes 27 No Director Silver Spring MD Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20906 United States 3701 International Dr. #512 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 □XYes 2 □ No If Yes, Give WW Year or Dates: 1 ☐ Yes 2XXNo White Specify: TŢ Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Sales Furniture 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Esther Lerner Louis Lerner မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Neil H. Offer (nephew) 7210 Pomander Ln. Chevy Chase, MD 20815 Date 16, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Jan. 1 ☐ Burial 2 ★ Cremation 3 ☐ Removal from State Beltsville, MD 2010 Chesapeake Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilityRapp Funeral & Cremation Service 933 Gist Ave. Silver Spring, Maryland 20910 M00982 23a. Part 1. Enter the diseas , or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Sepsis disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Clostridium Difficile Colitis Sequentially list conditions, any, and in the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner law requires that the death certificate be executed Acute Renal Failure physician and s the burial-trans Due to (or as a consequence of): Box 68760. Physician/Medical Congestive Heart Failure attending p for use as 1 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 ☐ Other (specify) signed by the a P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Failure to thrive Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy perform 2X No 1 ☐Yes 2 ☐No 1 ☐ Yes director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2XXVo 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To After thi funeral of 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 1 X Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No thin 24 hours after death.

the Funeral Director: A mpletely filled in by the fu 2 Accident 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 152 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only

State Registrar

1500 Forest Glen Rd. Silver Spring, MD. 20910 M.D. Delroy Anglin 32. Registrar's Signature

and manner stated.

30. Name and address of person who completed cause of death (Hem 23a) (Type, Print)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)



29c. License number

D55148

29d. Date signed (Month, Day, Year)

January 15, 2010

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760,

		Please Type or Prir State of Ma	nt in Black Ir aryland / Dep			-	_	
	1	For State Registrar	Ce	ertificate of	Death	Re	g. No 2 0 1 0	00759
Physicia /Medic	n	1. Decedent's Name (First, Middle, Last)	DNEY			2. Date of Death Month	Day Year	3. Time of Death 15. 12 P M
Examine		4a. Facility Name (If not institution, give street and number) MARTUAND GEMMAL	HOSPICAL		Location of Death		4c. County of Deat	
Funeral Director		5. Social Security Number 219−22−6660 6. Sex 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	e (In yrs. last birthday 91 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Jul. 6,	9. Bir 1918 M	thplace (State or Foreign ountry) aryland
show		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or L					10d. Inside City Limits 1t☑Yes 2 ☐ No
or 28a-f	Director	MD N/A 10e. Street and Number 2417 Herkimer Street		Baltimor	21230	10	g. Citizen of What Co	puntry?
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Important: If tem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If a Medical Evaninar must be notified at once.	∄│	11. Marital Status 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married	Ever in U.S. 13	. Was Decedent of H	dispanic Origin? (Spean, Mexican, Puerto f	cify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	erican Indian,
thin 72 hours le. "natural" In alice	Completed by	3	(Giv	DO NOT use retired	during most of workir d)		6b. Kind of Business	
ild be filed wi fental Hygien rked other th	To Be Con	7 17. Father's Name (First, Middle, Last) George E. Ensley		Glass Pac	18. Mother's Name	(First, Middle, M va May T	laiden Surname)	and Glass
nd 2 shou alth and N 27 Is mai		19a. Informant's Name/Relationship (Type. Print) James Loney - Son		_	and Number or Rura		City or Town, State, MD 21090	Zip Code)
ages 1 a ent of Hei		20a. Method of Disposition ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Disp cemetery, cre Cedar Hi	position (Name of ematory or other place 111 Cemete	ne) 1		Brooklyn I	
permit. Popartm Importal any injuron		21. Signature of Funeral Service Liceusee	+	22. Name and Addre	oo or raomy		neral Home sdowne, M	
. Physician		23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each limmediate Cause (Final	the death. Do not ene.		ng, such as cardiac o	r respiratory arre	est,	Approximate Interval Between Onset and Death
/Medical Examiner		resulting in death) Due to (or as	a consequence of):					
executed n and ial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.	a consequence of):	DRAFIG				
be be bur			a consequence of):	FAIL	INE			
ath certif attending for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown		23d. Date of delivery Month Day Ye				
w requires that the de been signed by the should be detached	þ	Part II. Other significant conditions contributing to death b	23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown					
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siclan s certifi	Be C	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpation	ent 2 ☐ ER/Outpati	ent 3 🗆 DOA Oth	26. Place of Death	,	nce 6 □Other (Spe	20164)
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al or Atte s after des il Directol	Certification:	3 Suicide 6 Could not be determined 28e. Place of inj building, et	ury - At home, farm, s c. <i>(Specify)</i>	street, factory, office	2	28f. Location (Str City or Town	reet and Number or Fi , State)	tural Route Number,
To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical O	29a. Certifler (Check only) 2□ Medical Examiner: On the basis of and manner st	of examination and/or					
To the within To the company	Σ	29b. Signature and title of certifier A T	TENDING	29c. Licens	se number		9d. Date signed (Mon	
6		30. Name and address of person who completed cause of c	death (Item 23a) (Type	e, Print)	PLAZE	furt !	34 Anim	Paris GU yus
Sta Registra	_	31. Date filed (Month, Day, Year) 32 Registr	rar's Signature	Barker				

DHMH 17 Rev 1/2001

LEARD, 4 ELEN MR# 219186321

		1 _ State	-	partment of Heartificate of De		tal Hygien Reg. N	2010	00760
Physici	an/	1. Decedent's Name (First, Middle, Last)		711110410 01 20	2. 🖸	Date of Death	ay Year	3. Time of Death
Med Exami	ical	Helen B. Leard 4a. Facility Name (if not institution, give street and number)		4b. City, Town, or Lo		Jan 14		
) Exami	nei	Good Samaritan Hospita		Baltimon	е		o. Godiny or Boar	
Funera Directo		219-18-6361 1 M 2 🕮 F	e (In yrs. last birthday) 85 Yrs.		Hours Min. 8. D	Date of Birth Month, Day, Year) DV. 16, 19	9. Bir 24 Man	thplace (State or Foreign untry) Yland
rland f show id at	tor	Usual Residence of Decedent 10a. State 10b. County MD Baltimore	10c. City, Town or L					10d. Inside City Limits
he Mary or 28a-i on otifie	Direc	10e. Street and Number	NOT	tingham 10f. Zip Code		10a. C	citizen of What Co	1 Yes 2 X No
th with t ns 23a must be	Funeral Director	190 Jumpers Circle		21236			U.S.A.	
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Fu	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced 12. Was Decedent 1 Armed Forces? 1 □ Yes 2 ☒ If Yes, Give Year or Dates.	. No	. Was Decedent of Hispa If Yes, specify Cuban, N	Mexican, Puerto Rican	res or No- n, etc.)	14. Race - Ame Black, White Specify: Whi	e, etc.
215-(mplet	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5	(Give	edent's Usual Occupation e kind of work done during DO NOT use retired)	on ng most of working	16b.	Kind of Business	
d withir dygiene ther the nt, the	Be Co	8)+)	Homemaker			At Hom	.e
/lanc d be file dental H arked o	일	17. Father's Name (First, Middle, Last) Charles F. Brown		18	3. Mother's Name (Firs Helen La		i Surname)	
, Maryland 21215-0036 td 2 should be filed within 72 hours after salth and Mental Hygiene. n 27 is marked other than "natural", o er traumatic event, the Medical Exam		19a. Informant's Name/Relationship (Type, Print) Christopher Clifford/ So		iling Address (Street and 21 Seven Cou	Number or Rural Rou Ints Drive			vland 21236
Baltimore, permit. Page 1 and Department of Hea Important: If item any injury or other once,		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Disp cemetery, cre Parkwood	cosition (Name of ematory or other place) Cemetery	01/18		Location - City or kville,	Town, State Maryland
Balt permit. Depart Import any inj		21. Signature of Funeral Service Licensee	18	Evans of Address 8800 Harford	Tremapel Rd. Park	& Crematic ville, MD	n Servi 21234	œs
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⊸ Pπysician. ∮ Medica		Im /ediate Cause (Final disc ase or condition resulting in death) a. Due to (r as	a consequence of):	T A				Onset and Death
Examine		alno		DIFFICIL	E.			
uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events c.	a consequence or.					
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68760 certificate b iding physicse as the b	Medical	IF FEMALE:						
Division of Vital Records, P.O. Box 68/60 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	23b Was decedent pregnant 23c. If yes, outcome	2 Fetal death 3	Control of the contro			23d. Date of de Month	livery Day Year
VItal Kecords, P.O. vsician: The law requires that the certificate has been signed by director, page 2 should be detail	þ	Part II. Other significant conditions contributing to death to						the cause of death?
ords require been s should	leted	CARDIOMYOPATHY,		CANCED		1 ∐ Yes 2 24a. Was an	24b. Were au	topsy findings available
Hec The lav	Completed	C TIN JALON JOPH 1-17	040113	OHIYORA	•	autopsy performed? 1 Yes 2	death?	completion of cause of
/Ital rsician: s certific	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital:	ient 2 🗆 ER/Outpati	_ Other	of Death (Check only		6 Other (Page	<i>i6.</i>)
ding Phy After thi		27. Manner of Death 28a. Date of inju 1N⊒Natural 5 ☐ Pending (Month, Da	ıry 28b. Time	of 28c. Injury at work?		Describe how inju		
DIVISION OF tal or Attending PP rs after death. al Director: After th ed in by the funeral	Certificate:	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injudiding, et	ury - At home, farm, s c. (Specify)		28f. L	ocation (Street a Dity or Town, Stat		ral Route Number,
Hospita 24 hours Funeral eted filler	Medical	29a. Certifier (Check 2 Medical Examiner: On the basis of only one) 3 Certifying Nurse Practioner: To the	examination and/or inve	estigation, in my opinion, o	death occurred at the ti	ime, date and plac	e, and due to the	cause(s) and manner stated.
To the within To the COMP	2	29b. Signature and title of certifler	best of my knowledge	29c. License nu	ımber	29d. D	ate signed (Month	n, Day, Year)
la W		30. Name and address of person who completed cause of c	death (Item 23a) (Type,	Print)	5601 Loch	Raven	BIVA	
	ate	31. Date filed (Month, Day, Year) 32. Regis	ar's Signature	1103 91104	13 artimor	6, M/) -	21239	,
Regist	rar	JAN 19 2010 💆	example	parked				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2010 2:53 p Wade Hampton Lange, Sr January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sykesville Carroll Transitions Healthcare If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day **June** 30 Social Security Number 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign **Funeral** 1 XM 2 | F Months Days Hours Min. Year) 1941 Maryland 68 Director 218-40-9535 June Usual Residence of Decedent show or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Carrol1 Sykesville Maryland 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? ò an "natural", or items 23a o Medical Examiner must be Funeral United States 1000 Buckhorn Road 21784 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married δ Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: 3 Uldowed 4 Divorced Completed White 16a. Decedent's Usual Occupation 16b. Kind of Business Industry oe filed with. Mental Hygiene. ✓ other than "r (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Owner Restaurant Be Department of Health and Mental Hy Important: If item 27 is marked ott any injury or other traumatic even once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ည Edward Milton Lange Myrtle Irene Wisnom 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christina Kleinschmidt/Daughter 6414 Amherst Avenue, Columbia, Maryland 21046 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Januarv 18. 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 2010 Baltimore, Maryland 22. Name and Address of Facilin Cremation Society of Maryland, Inc. 21. Signature of Funeral Service Licensee Amanda Heaston Dun 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Equiportially flat conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) ettending physician and or use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of deliven Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Year Day Pregnant at time of death been signed by the should be detached g Unknown g Unknown P.O. or Attending Physician: The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖫 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 s EMIA performe 1 Yes 2 No Yes 2 X N 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Hospital: Other: 1 🗌 Yes 2 **X**No ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital 29a. Certifier Xertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Kanery

349 Maccolm Drine, Wereminita MD 21157

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Year Month **Physician** Mary Louise Ludwig 18. 2010 12:25 <u>January</u> /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Somerford Assisted Living Howard Columbia 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Months Days 1 □ M 2 👿 F **Director** 218-09-9303 90 02-08-1919 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Medical Examinar mans the metiting. 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director MD Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5049 Ten Mills Road Completed by Funeral 21044 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2x XNo Specify. Specify: 3 X Widowed 4 ☐ Divorced White Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Chester Clarence Jollett Cora Eliza Morris 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5049 Ten Mills Road, Columbia, Maryland 21044 Linda C. Ritter - Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Mem Pk. Elkridge, Maryland 01-23-10 22. Name and Address of FacilityGary L. Kaufman Funeral Home at o Funeral Service MMP., Inc., 7250 Wash. Blvd., Elkridge, MD 21075 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Pneumonia 9 days disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and Cause (Disease or inju that initiated events resulting in death) Last and burial-tra Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month 5 Other (specify) 1 ☐Yes 2 ☐ No the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Congestive Heart Failure 1 Tes 2 No 3 Probably 4 Unknown Completed Cerebral Vascular Accident (CVA) 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Aortic and Mitral Regurgitation 1 ∐Yes 2 🛣 No 1 ∐Yes 2 🛣 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Assisted Living Other: 4 Nursing Home 5 Residence 6 Charlet (Specify) Hospital: 1 ☐ Yes 2XX No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in by 4 Homicide 24 hours a Medical 29a, Certifier Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D-56531 Jan. 18, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar 301, Columbia, MD 21045

Harry Li, MD, 8600 Snowden River Pkwy,

32. Registrar's Signature

31. Date filed (Month, Day, Year)

			Please	Type or Print amend ite State of Mary	in Black II m 30 per land / Den	ndelik r dvr arfme	ole ink	C. Ensure A 1–19– lealth and i	All Copie IO vt Menfal Hy	s Ar gien	e Legible. e	•
			_ State Registrar				te of E			Reg. N	0010	00763
	Physicia Medic		1. Decedent's Name (First, Middle, Las	ester Lau	v.(m				2. Date of De Month	eath P	ay Year	3. Time of Death
	Examin	er	4a. Facility Name (If not institution, give	Ap.	t.125			Location of Death imore	1	4	c. County of Deat $\mathrm{N/A}$	h
	Funeral Director		5. Social Security Number 6. Social Security Number 1 2 1 5 - 1 2 - 9 6 8 9		vrs. last birthday) Yrs.	If Und Months	er 1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da Apr 3		9. Bird Co. 19 Mar	thplace (State or Foreign unity) y Land
	aryland ia-f show ified at	ector	Usual Residence of Decedent 10a. State 10b. County Maryland N/A	100	:. City, Town or Lo Baltimo	ocation ore						10d. Inside City Limits 1 ♀ Yes 2 ☐ No
	with the M s 23a or 28 ust be not	Funeral Director	10e. Street and Number 501 E. Presto	n Street ^{Ap}	t.125	10f. Z	p Code 212	:02		10g. C	itizen of What Co	41
9036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ever i Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates.	n U.S. 13.	If Yes, spe	cify Cuba	spanic Origin? (Sp n, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	-	14. Race - Ame Black, White Specify:Bla	e, etc.
215-(nin 72 hou ne. han "nati e Medica	Completed	15. Decedent's E (Specify only highest gre Elementary/Seconday (0-12)		16a. Dece (Give life. D		ork done d	ation luring most of wor	king	16b.	Kind of Business	Industry
d 21	led with Hygier other t ent, th	Be	11th grade 17. Father's Name (First, Middle, Last)		Cros	sing	Gua	rd 18. Mother's Nar	ne (First, Middle,		<u>ltimore</u> Surname)	City
ylan	uld be fi Menta narked natic ev	욘	Harry Chase					Anna Fo	ord			
Baltimore, Maryland 21215-0036	and 2 shou lealth and im 27 is n her traum		19a. Informant's Name/Relationship (T) Jerome Lawson	/Son	501	E. P	rest	on Stre				timore,MD
imore	Page 1 ament of Hant: If ite		20a. Method of Disposition 1	Pomoval from State	ob. Place of Dispo cemetery, crei	matory or	other place	ery 1/19	Date 9/10]	i	ocation - City or downe,	Town, State Maryland
Balt	permit Depart Import any inj once.		21. Signature of Funeral Service License	e di Min	52	2. Name a 240	nd Addres Reis	stersto	atman-I vn Rd I	Harı Balt	ris Fun Limore,	eral Home MD 21215
	Physician/		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition	olications that caused the ne cause on each line.	death. Do not ent		de of dying	g, such as cardiac	or respiratory ar	rest,		Approximate Interval Between Onset and Death
اسسا	Medical Examiner		resulting in death)	Due to (or as a con	sequence of):		- HUA	IULIUUS				
	uted d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events	Due to (or as a con	sequence of):							
. 00	te be executed nysician and he burial-transit	g	resulting in death) Last	Due to (or as a cond.	sequence of):							
. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate is within 24 hours after death. Within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys completed filled in by the funeral director, page 2 should be detached for use as the laws.	Completed by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome of pri 1 ☐ Live Birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	Ectopic Other (s	pregnancy pecify)	у			23d. Date of del Month	ivery Day Year
s, P.O	ires that th signed by Id be deta	ed by Pi	Part II. Other significant conditions of HTW	ontributing to death but no	t resulting in the ι	underlying	cause giv	en in Part I.	23e. Did t			the cause of death?
Division of Vital Records, P.O.	rs ician: The law requ s certificate has beer lirector, page 2 shou	omplete	Dement	ha		•			24a. Was auto perfo	psy ormed?	prior to death?	copsy findings available completion of cause of
tal	ician: 1 sertifica ector, p	Be	25. Was case referred to medical examiner?	Hospital:			1	ace of Death (Chec		2 10 1	10 100	2 2 110
of V	g Phys er this eral dir	te: To	27. Manner of Death	1 Inpatient 28a. Date of injury	2 ER/Outpatier 28b. Time of		28c. Injury	4 ∐ Nursing H at	ome 5 Resi		6 Other (Speci ry occurred	fy)
ion	ttendin death. tor: Aft the fur	Certificate:	1 Natural 5 ☐ Pending 2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be			М		? Yes 2□No				
Divis	To the Hospital or Attending Physician: The la within 24 hours after death. To the Funeral Director: After this certificate ha completed filled in by the funeral director, page		4 ☐ Homicide determined	28e. Place of Injury - A building, etc. (Sp	ecify)				City or Tov	vn, State		
	he Hos iin 24 hc he Fun	Medical	(Check 2 Medical Exami	sician: To the best of my k ner: On the basis of examir se Practioner : To the best	iation and/or inves	tigation, in	my opinio	n, death occurred a	at the time, date a	and place	e, and due to the c	ause(s) and manner stated.
	To t		29b. Signature and title of certifier	ΛΛο		29	c. License		7	29d. Da	ite signed (Month	
	2./		30. Name and address of person who c					006426	1 /		i - 15-	
	Stat	e	31. Date filed (Month, Day, Year)	32. Registrar's S		1	827	Linden A	ve. Bal	to.	Md. 212	01
	Registra	_	JAN 192	1010 Seneura	1. 4	San						

Allester Lawson

For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Robert F. Lilley 14,_ January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Alice Manor Nursing Home Baltimore
Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

June 27,1920 Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months 1□M 2√X Davs Hours 89 Director 119-03-7225 Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 28a-f show or other traumatic event, the Medical Examinar must be notified at MD N/A Director Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ŏ 2095 Rockrose Avenue 21211 U.S.A. 14. Race - American Indian, Funeral permit. Pages 1 and 2 should be filed within 72 hours after death Department of Heatth and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23 any Injury or other traumatic event, the Medical Exa. If not must 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ Volo If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2**XX**No Specify. ģ Specify. 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Building Inspector City of Baltimore 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mervin E. Lilley Beulah Bickell ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elspeth B. Wheeler (POA) 3935 Keswick Road Balto, MD 21211 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 01/16/2010 Glen Burnie, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home 3631 Falls Road Balto, MD 21211 shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** eumomia disease or condition resulting in death) /Medical Due to (or as a consequence of) Disase Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine **Hospital or Attending Physician:** The law requires that the death certificate be executed 24 hours after death. and Due to (or as a consequence of) attending physician Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 5 ☐ Other (specify) ☐Yes 2☐No the o 9 Unknown 9 Unknown ٣. ģ signed 1 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 9 Completed 24a. Was an has certificate 1 TYes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 1 Yes 2 16 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated 29b. Signature and title of certifier

Name and address of person who completed cause of death (Item 23a) (Type, Print)

821

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

State Registrar

IADA

DHMH 17 Rev 1/2001

ORIGINAL

N-ENEWST

Month Year Day 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Onknown

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes

12:30 PM

Birthplace (State or Foreign Country)

10d. Inside City Limits

Yes 2□No

2010

MD

Black, White, etc

White

Other: Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Baltimore

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Frank Paul Liersemann Sr. 2. Date of Death 3. Time of Death Physician/ .^{Da}ž2010 January 15, 3:34 AM Medical Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Baltimore **Examiner** 4c. County of Death Baltimore 8610 Wendell Avenue Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 215-14-8413 1 **火** M 2 □ F 84 Months Days Hours Min. March 4, 1925 Director Mary Tand Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Directo Maryland Baltimore Baltimore 1 ☐ Yes 2 🙀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8610 Wendell Avenue 21234 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces Black, White etc. 1 Never Married 2 Married þ XXYes 2 No WWII Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify: Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Automobile Sales Automobile Dealership Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Richard Liersemann Lola Heinbach 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Boute Number, City or Town, State, Zip Code 2420 Abigail Court Prince Frederick Maryland 20678 Rev. F. Paul Liersemann, Jr. / Son 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Durial 2 Cremation 3 Removal from State Hilltop Service Corp. 4 Donation 5 Other (Specify) 1/16/2010 Towson Maryland 22. Name and Address of Facility Leonard J. Ruck Inc 5305 Harford Road Baltimore Maryland 21214 Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence Examiner Sequentially list conditions. if any, leading to immediate cause Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami the attending physician and hed for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year 1 Yes 2 9 Unknown g Unknown signed by t Id be detach Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has birector, page 2 sl autopsy performe 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?

1 Yes 2 No funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home မ 1 Inpatient 2 ER/Outpatient 3 DOA this 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 1 Natural injury 5 Pending work? To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Af completed filled in by the fu 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 🔟 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10x1 State

Registrar
DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ anuar noore Medical acility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death County of Death Ba timore 8. Date of Birth 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. **Funeral** 1 🗆 M 2 🗷 F Min. 241 Director iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b, County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a Funeral Melbourne 21229 death v 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, 1 Never Married 2 Married Completed by Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 ☑ No Iac Specify. Specify: 3 Divorced 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) pe mit. Page 1 and 2 should re filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than an injury or other traumatic event, the Me oonday (0-12) College (1-4 or 5+) 00 K Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Informant's Name/Relationship (Type, Print) (Streetjand Number or Rural Route Number, City or Town, State, Zip Code) Mailing Addres 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State 4 Donation Other (Specify) त्रा यूर्य 9 Signature of Name and Address of Facility Balto MD Part Ene, he isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, it is art failure. List only one cause on each line. Approximate Immediate ase (Fi Physician/ Medical resulting in death) **Examiner** Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury as the burial-transit and that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) Yes 2 No signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 1 Yes 3 Probably 4 Unknown within 24 hours after death.

To the Funeral Director: After this certificate has been si completed filled in by the funeral director, page 2 should I Were autopsy findings available prior to completion of cause of 24a. Was an To the Hospital or Attending Physician: The law autopsy death? Be 25. Was case referred to predical examiner? **Division of Vital** 26. Place of Death (Check only one) 은 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28b. Time of 27. Manner of Death 28a, Date of injury (Month, Day, Year) 28c, Injury at work? 1 ☐ Yes Certificate: 28d. Describe how injury occurred Natural 5 Pending injury 2 No Accident Suicide Investigatio 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) (Type, Prin trar's Signature **State** Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year ZOID Physician/ 1709 M Sinclair Medical 4a. Facility Name,(if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Maryland Medical Center of Baltlmore Universit 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** (Month, Day, Year)
Nov 24, 1 2 M 2 D F Days Hours Country) Director 64 1945 Marvland 213-46-1836 Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits death with the Maryland Director 1. Yes 2 No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funera 21212 United States 6302 Bellona Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?
1 ☐ Yes 2 █ No Black, White, etc. \$ 1 Never Married 2 Married hours after Maryland 21215-0036 1 Yes 2 No Specify: If Yes Give 3 Widowed 4 Divorced Completed White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) should be filed within 72. h and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Telecommunication permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Elizabeth Douglas John Beverly Miller 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hart /Daughter 240 E. 76th Street 6D New York, NY 10021 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Jan 19 Beltsville, Maryland Chesapeake Cremator 2010 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Funeral Alternatives Pastures Drive Towson Maryland 23a. Part 1. Ener the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Physician/ oronary Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) that initiated events resulting in death) Last and-trar Due to (or as a consequence of): by the attending physician tached for use as the bunal the burial Physician/Medical certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death Ectopic pregnancy in the past 12 months?
1 Yes 2 No requires that the death Pregnant at time of death Dav Other (specify) be detached PO Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed I 2 2 No 3 Probably 4 Unknown Records, Completed should peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? Yes 2 No Physician: The law has page 2 To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I 1 Yes 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be examiner? 2 No Other: 1 🗌 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27, Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) injury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Accident Investigation the 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office bullding, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 [only one) 29b. Signature and title of certifie M.D. lan Name and address of person who completed cause of death (Item 23a) (Type, Print) Greene 22 Matthe 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #18 Per FH G899 1/26/2010 JH State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Manning 1523 M heile Medical Janvar 2010 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Semestay Hospital 5. Social Security Number 217 - 86 -8657 7. Age (In yrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) 1 □ M 2 😿 F Months Days Hours Min. (Month, Day, Year) 45 Director MARI Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a. State 10d. Inside City Limits within 72 hours after death with the Maryland 10c. City, Town or Location Director MD BALTIMORE 1 Yes 2 No 10e, Street and Number 10g. Citizen of What Country? Funeral 2403 West FIELD 2121 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc δ 1 Never Married 2 Married 1 Yes 2 No Maryland 21215-0036 1 ☐ Yes 2. No Specify. "natural", Specify: BLACK 3 Widowed 4 Divorced Completed Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) MEDICAL BUSINESS MANAGER Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ JOHNSON SRACIE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GRACIE MANNING MOHLER 1524 PLACE BAL TIMORE, MARYTANG Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State BALTIMORE, MARYIAND 21/2010 KING MEM. PK. CEME 4 Donation 5 Other (Specify) DERRICK Signature of Funeral Sentice License L. JONES FIH, P.A. BALTIMORE, MARYIAND 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Due to (or as a consequence of): Interestion disease or condition Medical resulting in death) Éxaminer Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-tran resulting in death) Last Due to (or as a consequence of) attending physician I for use as the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? detached for Month Day Unknown the 9 Unknown P.O. by Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ be Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 10003 should Hypetens:on 24a. Was an 24b. Were autopsy findings available page 2 has autopsy prior to completion of cause of death? performed? Yes 2 2 No Morbid this certificate Obes: + 1 Yes 2 No Division of Vital 25. Was case referred to medic director, æ 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 2 🗌 No 1 Inpatient 2 ER/Outpatient 3 IDOA funeral 27. Manner of Death Certificate: 28a. Date of injury 28h Time of 28c. Injury at 28d. Describe how injury occurred After 1 X Natural (Month, Day, Year) 5 \square Pending work? 1 ☐ Yes 2 ☐ No death. Investigation ☐ Accident the 24 hours after deatl Funeral Director: 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical 29a. Certifier 💋 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death paccurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2 only one) 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) H0059388 -13-2010 CF 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar David Weisman

5601

Blud

Baltimore mo

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. T= State of Maryland / Department of Health and Mental Hygiene 29d per dr.,g899.01/.19/09dhb

Certificate of Death

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month McGregor 2010 Marvin 7:40 A January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Anne Arundel 433 Brooks Court Glen Burnie 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🛛 M 2 🗆 F Months Days Hours Min. (Month, Day, ept. 2 Maryland Director Sept. 944 215-44-9143 Usual Residence of Decedent 28a-f shov 10a. State item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Anne Arundel Glen Burnie 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 433 Brooks Court 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 X Married þ 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: If Yes, Give Year or Dates Specify: 3 Widowed 4 Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene. life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) S X Railroad Electrical Foreman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ McGregor Mary Elizabeth Richardson <u> Harold</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 433 Brooks Court Glen Burnie, Maryland 21060 Kathleen McGregor (Wife) 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place, 01/13/10 Glen Haven Mem. Pk. Glen Burnie, Maryland 21. Signature of Funeral Service Licensee ^{22. Name and Address of Facility} McCully-Polyniak Funeral Home, P.A. <u>3204 Mountain Road Pasadena. Maryland</u> 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retw Immediate Cause (Final Physician/ MYOLA disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Year signed by the a d be detached f 2 🗌 No 9 Unknown 9 Unknown P.O. | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Jas 1 Yes 2 No 25. Was cas referred to medical Vital Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 1 No မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home Division of 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending after death. 2 Accident
3 Suicide Investigation М within 24 hours after death

To the Funeral Director. / 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined Medical 29a, Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number January 8 2010

Registrar

person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Ada Selma Markowich 2010 ear January 4:35 aM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death National Lutheran Home for the Aged Rockville Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last hirthday) 8. Date of Birth (Month, Day, Year, NOV 22 1 **Funeral** Birthplace (State or Foreign Days Min. 1 □ M 2 🖫 F Hours 183-01-1297 90 Director PA 1919 Nov. Usual Residence of Deceder 28a-f show 10a, State the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Howard Woodbine 1 Yes 2 X No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 2115 Duvall Road 21797 USA items 2 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian Black, White, etc. "natural", or δ 1 Never Married 2 Married Maryland 21215-0036 1 Tes 2 No Specify. Completed 3 XWidowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit, Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked of any injury or other traumatic eve ည Benjamin Canter Fannie Farber 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Judy Lynn Johnson / Daughter 2115 Duvall Rd. Woodbine, MD 21797 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crem. 1/17/2010 Woodbine, MD SEFuneral Service Licensee Dorrota Marshall 22. Name and Address of Facility Maryland Cremation Services 23a. Part 1. Enter the disease, or complications that caused the death.) o not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Baltimore, MD Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or i that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 month Month Day Year Pregnant at time of death
Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Yes 2 No 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 27. Manner Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 73 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) Signature and title of certifier . Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 7/2009

State

Damascus,

26033 Ridge Road

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's

M.D

Charles Karesh,

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

JAN 19 2010 Jenus S. A

Baltimore, Maryland 21215-0036

P.O. Box 68760

Records,

Vital

Division of

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) Carolyn Melton 2. Date of Death $^{3.}$ Time of Death 11:30 p_{M} Physician/ Month. 12 Day 2010 Year Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Baltimore Highlands 3016 Ohio Ave. 7. Age (In yrs, last birthday) Birthplace (State or Foreign Country) MD . Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 214-44-5869 1 M 2 X F Hours 1(6001,02x149245 Director Jsual Residence of Decedent shov should be filed within 72 hours after death with the Maryland and Mental Hygiene.
'is marked other than "natural", or items 23a or 28a-f shoraumatic event, the Medical Examiner must be notified at 10b. County
Baltimore 10a State ^{10c.} City, Town or Location Baltimore Highlands 10d. Inside City Limits Director 1 Tyes 2 TX No 10f. Zip Code 21227 10e. Street and Number 10g. Citizen of What Country? Funeral 3016 Ohio Ave. United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Force Black, White, etc. ģ 1 Never Married 2 Married Yes 2 No 1 ☐ Yes 2 🛛 No Specify: If Yes, Give Specify: WHITE 3 Divorced Completed Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be f Department of Health and Menta Important. If item 27 is marked any injury or other traumatic ev 2 Charles Wise Lenora Schelhause 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zin Code), 3016 Ohio Ave. Baltimore Highlands, MD 21227 William Melton - Husband 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (C) 20b. Place of Disposition (Name of 20c. Location - City or Town, State 01-15-2010 Anne Arundel County, MD G1cemeter arematory Mether plane 1 Donation 5 Other (Specify) 22. Name and Address of Facility Ambrose Funeral Home of Lansdowne 2719 Hammonds Ferry Road Halethorpe, MD 21227 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Immediate Cause (Final END STAGE Physician/ RENAL DISEASE disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine ii any, leading to immediate cause. Enter Underlying Due to for as a consequence on and I-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last physician a sthe burial-1 Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Pregnant at time of death Dav Year 2 🗆 No 9 Unknown Unknown signed by i Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by OBSTRUCTIVE PULMONARY has been signed to should to 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page performed? Yes 2 No 1 🗌 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 2 X No မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA Nursing Home 5 🛽 Residence 6 🗆 Other (Specify) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760

Maryland 21215-0036

Baltimore,

After this certificate I funeral director, page Certificate: within 24 hours after death.

To the Funeral Director: A completed filled in by the fu Medical

28a. Date of injury (Month, Day, Year) 28c. Injury at 1 X Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year)

18065 861

13/2010

MO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hasan Awan MD 2717 Hammonds Ferry Road Lansdowne MD 21227 31. Date filed (Month)

State Registrar

			1 - For State Registrar	State of Maryland			of Health a			giene () (0 007	73
	Dhusia		1. Decedent's Name (First, Middle, Last)				2	Date of De		3. Time of D	eath
	Physic /Medi		Robert Emmitt	McIntyre					Jan.	14, 2010		М
	Examir	ner	4a. Facility Name (If not institution, give			4b. City, To	wn, or Location			4c. County of 0	Death	
			3405 Parkside Dr			If Under 1	Baltimo			N/A		
	Funeral Director		5. Social Security Number 6. Se 219–22–3984	7. Age (In yrs. Ia	Yrs.		Days Hours	Min.	Date of Bir (Month, Da Feb. 2	26, 1927	Birthplace (State or F Country) Maryland	Foreign
	ehow		10a. State 10b. County	10c. City,	Town or Lo	cation					10d. Inside City	Limits
	Mar.	ş	Maryland N/A		Balt	imore					1 🙀 Yes 2	2 □ No
	or 28)Ire	10e. Street and Number			10f. Zip C	ode			10g. Citizen of Wha	t Country?	
	ath w	ra	3405 Parkside Dri	ve			21214			United St	ates	
21215-0036	72 hours after death with the Maryland natural', or iteme 23a or 28a-f ehow disal Examinat must be notified at	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1		Was Deceder If Yes, specify 1 ☐ Yes 2 ☐	t of Hispanic Ori Cuban, Mexican No Specify:		fy Yes or No can, etc.)	14. Race - / Black, V Specify:	American Indian, White, etc. White	
9	72 hours "natural",	ted	15. Decedent's Edu	cation	16a. Dece	dent's Usual C	occupation			16b. Kind of Busin		
2	be filed within 72 hatal Hygiene. d other than "nature.event, tre Medical	Completed	(Specify only highest grad	College (1-4or 5+)	life.	DO NOT use	done during mos retired)	it of working				
	filed w Hygier ther th		12		Stoc	king	1			Food Inc	lustry	
anc		Be	17. Father's Name (First, Middle, Last) Robert McIntyre						First, Middle, Ke1	, Maiden Sumame)		
Maryland	d 2 should the and Ment 7 is marked traumatic	မ	19a. Informant's Name/Relationship (Ty	ne Print)	19h Mailir	na Address (S	Eliza			er, City or Town, Sta	to Zin Codo)	
N S	7 10		Robert Saltysiak/							e, Marylar		1
re,	es 1 and of Healt fitem 2: r other		20a. Method of Disposition	20b. Pla	ce of Dispo	sition (Name natory or othe		anuary	-	20c. Location - City		
Ĕ	Pagent ent t: f		1 ☐ Burial 2 ③ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	•	matory		2010		Baltimore	, Maryland	
Baltimore,	permit. P Departm Importar eny injui		21. Signature of Fyheral Service Licens		on 22	. Name and	ddress of Facilit	Crema	tion	Society of	f Maryland Land 21228	,Inc
>	Physician /Medical		23a. Part1. Enter the disease, or compl shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	cations that caused the death. te cause on each line. Due to (or as a conseque							Approximate Interval Betwee Onset and Dea	en
	Examiner		Sequentially list conditions	arteni	oscle	roto	CoV	o de	Sei	se	4 Ethe	2
	cuted nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conseque	nce of): ひじ	,	HTM	U			Emn	5
8760,	cate be executed physicien and the burial-transit	dical Ex	resulting in death) Last	Due to Lr as a conseque	nce of):	, (Mel	erli	ち		YIM	4
Box 6	death certifi e attending id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnand 1 □ Live birth 2 □ Fetal d 4 □ Pregnant at time of dea 9 □ Unknown	eath 3	Ectopic pregr Other (speci				23d. Date of Month	delivery Day Yea	ar
	w requires that been signed b should be deta	þ	Part II. Other significant conditions cor	tributing to death but not result	ing in the ur	nderlying caus	e given in Part I.		23e. Did to		e to the cause of dea	
Division of Vital Records,	Physician: The law requires that the this certificate has been signed by the rail director, paga 2 should be detached.	Completed										arlable se of
Ξ	sicia certi irecto	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	ospital:	210		Other		Check only o			
of	y Phy er this eral d	7. To	27. May er of Death	Tax - T	Outpatien 8b. Time of		4 □ Nu Injury at Work?			dence 6 Other (5	Specify)	
<u>o</u>	Attending ir death. ector: After by the funer	ate	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	М	Work? 1 ☐ Yes 2 ☐ i			, , ,		
Divis	p # in in	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At hom building, etc. (Specify)	e, farm, stre	eet, factory, of	fice	28f	Location (S City or Tox		r Rural Route Number	r,
	To the Hospital within 24 hours a To the Funeral Completely filled	edical	29a. Certifier (Check only one) 12 Certifying Phys	ician: To the best of my knowler: On the basis of examination and manner stated.	edge, death n and/or inv	occurred at t restigation, in	he time, date and my opinion, deat	d place, and th occurred	due to the at the time,	cause(s) and manne date and place, and	r as stated. due to the cause(s)	
	To t To tll Comp	Ž	29b. Signature and title of certifier	^		29c. Li	cense number			29d. Date signed (M		
			1- Apira	lo(he		1	7327	17		1/15/2	510	
			30. Name and address of person who co	mpleted cause of death (Item 2	3a) (Туре, I	Frint)	biTAZ	in	- UN	TIFICHE	1 MM 21	080

DHMH 17 Rev 1/2001

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav Year Month 01:55 AM John Joseph McLaughlin Jan 14 2010 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death St. Agned
5. Social Security Number N/A HOSPI to Baltimone Birthplace (State or Foreign Country) 6. Sex If Under 1 Year | If Under 24 Hrs Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Months 1⊠M 2□F Days Hours 216-20-6180 83 1926 Maryland August 4, Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 Yes 2 □ No N/A Baltimore Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21229 507 Brisbane Road USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ∑Yes 2 ☐ No 1943 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ∑Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐Yes 2 🛣 No Specify: White 3 ₩ Widowed 4 Divorced 1945 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) Foreman's Clerk B & O Railroad 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Elsie Mae Sheets William Charles McLaughlin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5755 Applefield Path New Market, Maryland 21774 Karen Maben, Sister in law 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 01/18/10 Baltimore, Maryland Loudon Park Cemetery: Machabborreneral Home, P.A. 21. Signature of Funeral Service Licensee Thomas Gregor 301 Frederick Road Cátonsville, Maryland 21228 Momow Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Respiratory

Due to (or a a consequence of): disease or condition resulting in death) Mouth Pheurowa Sequentially list conditions, Due to for as a consequence of: cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Non Hodgkin I Due to (or as a consequence of): ears B ceil LYHDHOMO yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? Pregnant at time of death 5 Other (specify) ☐Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 □Yes 2 □No 1 ☐ Yes 2 ☑ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1- Inpatient 1 Yes 2 No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manper of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

certificate be execu and P.O. Box 68760, McLaughlin John Division of Vital Records,

Examine burial-transit the attending physician Physician/Medical the Por Completed page 2 Be ၉ Certification: completely filled in by the ical

Physician

/Medical

Examiner

Director

Funeral

2

Completed

Funeral

Director

?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Wealcal Examination or motified

72 hours after death with

should be filed within 7 and Mental Hygiene.

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event, once.

Physician

/Medical Examiner

3altimore, Maryland 21215-0036

signed by the a d be detached f

To the Hospital or Attending Physician: The law requi within 24 hours after death.

To the Funeral Director; After this certificate has been s

State

and manner stated. 29b. Signature and title of certifier Herma Sanopita

4 ☐ Homicide

29a, Certifier

29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

01.14.2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

900 VERMA Caton

Bailinore, MD

Registrar

Medi

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 20 10 1 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 01 Physician/ 0 7 Day 20¹0 C. 23:23 M Raymond McRoy Jr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Shady Grove <u>Adventist</u> Hospital <u>Rockville</u> <u>Montoqmerv</u> 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1**X** M 2 □ F Days Min. Months Hours Country) Director 218-54-5912 59 13 MD Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 Yes 2 X No MD Montogmery Germantown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12528 Cross Ridge Way 20874 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 XMarried within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2√ No Specify. Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working nd Mental Hygiene. marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) llth grade Pastor church na traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t. Page 1 and 2 should be filed tment of Health and Mental H tant: If item 27 is marked ot ည Raymond McRoy Sr. Rosalee Noland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) other Judy McRoy-Wife
20a. Method of Disposition 2528 Cross Ridge Way. Germantown, Md 20874 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1
Department of Important: If it any injury or o once. 1 ☐ Burlal 2 【 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) /18/2010 On-Site Baltimore, Md Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H West
4300 Wabash Ave. Raltin
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Baltimore, Approximate
Interval Between
Onset and Death
Minutes shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician/ Myocardial Infarction Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of) sician and burial-transit Due to (or as a consequence of) attending physician Physician/Medical as the l IF FEMALE: asn 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ for in the past 12 months?

1 Yes 2 No
9 Unknown Day Month Year Pregnant at time of death detached 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? cate has been signed page 2 should be del Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☒No 24a. Was an autopsy performed? Yes 2 No this certificate 25. Was case referred to medical examiner? the funeral director, Be 26. Place of Death (Check only one) Hospital 2 No Other: 2 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death.

To the Funeral Director: After 1 Natural 2 Accident injury 5 Pending Investigation M Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide completed filled in by determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) e. D64088 1/7/2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Md 20850 Shady Grove Hospital, 9901 Medical Center Dr, Rockville John Jones State Registrar

Baltimore, Maryland 21215-0036

68760

Box (

P.O.

Division of Vital Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 U 1 0 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month <u>Elsie Mae Mill</u>er 2010 8:10 Medical 4a. Facility Name (if not institution, give street and number) Glade Valley Nursing & Rehabilitation Center **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Walkersville Frederick Social Security Number 6. Sex 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2XXF Months Hours Director 185-28-1431 Marvland Nov Usual Residence of Decedent show 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at Directo 1 Tes 2XXNo Maryland Frederick Walkersville 10e. Street and Number 10g. Citizen of What Country? United States Funeral 56 West Frederick Street 21793 <u>America</u> 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married þ 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2XX No Specify. Specify: White Widowed 4 □ Divorced "natural" Completed Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any Injury or other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 8th Licensed Practical Nurse Healthcare Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည George Merryman Flora Fowble 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helen M. Rhodes (Daughter) Sunset Drive, Dallastown, Pennsylvania 17313 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Jan. 16, 1XX Burial 2 Commation 3 Removal from State 4 Donation 5 Other (Specify) Greenmount Ch. Cem. 2010 Greenmount, Maryland Signature of Fure ce Lic ^{22 Name and Address of Facility} Eckhardt Funeral Chapel, P.A. 3296 Charmil Drive, Manchester, Maryland 21102 3a. Part /. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Im ediate Cause (Final Physician/ tease or condition resulting in death) 1-2WK preumon. Medical Due to (or as consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events Due to (or as a consequence of): the burial-transi Due to (or as a consequence of): resulting in death) Last the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Year signed by the a d be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Hypertension 1 Yes 2 No 3 Probably 4 Unknown page 2 should been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performe death? 1 ☐ Yes 2 🛣 No 1 ☐ Yes 2 X No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) s after death. 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 2 Accident (Month, Day, Year) 5 Pending To the Hospital or Attendin within 24 hours after death.
To the Funeral Director: Af completed filled in by the fu 1 Yes 2 No Investigation 6 Could not be 3 Suicide
4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined | Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only on Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signat title of certifier 29d. Date signed (Month, Day, Year)

Registrar

State

trederick MD 21702

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

31. Date filed (Month, Day, Year)

JAN 19 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #8 per Fh 8899 1/22/10 TT
State of Maryland / Department of Health and Mental Hygiene 2 0 1 (Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year Moore **Physician** 12:31 14 2010 January /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner **Baltimore City** The Johns Hopkins Hospital | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Menth Day | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 | 1.00 5. Social Security Number 218 - 36 - 96 50
Usual Residence of Decedent Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Director 10d. Inside City Limits 10c. City, Town or Location or 28a-f show notified at 10a. State 10b. County 1 X Yes 2 □ No Funeral Director 10g. Citizen of What Country 10e. Street and Number ò ms 23a or must be r 2700 E. Oliver Street Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) items Pages 1 and 2 should be filed within 72 hours after Examiner 1 Never Married 2 Married Black 1 ☐ Yes 2 XNo Baltimore, Maryland 21215-0036 ö Specify: Specify: þ 3 Widowed 4 Divorced "natural", the succession of the successi Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Shovemar 18. Mother's Name (First, Middle, 17. Father's Name (First, Middle, Last) Be 100re ၉ Name/Relationship (Type. Print) Mailing Address (Street and Numb nt of Health a 20a. Method of Disposition 20b. Place of Disposition (Name of 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 6 Department of Important: If any Injury or 4 ☐ Donation 5 ☐ Other (Specify) any In Pair - Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death nexotheliana Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sepsis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed renal failure Due to (or as a consequence of) resulting in death) Last physician an Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy Month Day in the past 12 months? Pregnant at time of death 5 Other (specify) 2 No Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy 2 No Yes 1 Yes certificate 25. Was case referred to medical 26. Place of Death Check onl one Be examiner? Other: Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) No. ၉ 28b. Time of 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Natural (Month, Day Year, Injury 5 Pending 1 Yes 2 No investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fi 2 Accident in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (check only Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number ES 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gibbs 600 North Wolfe St, Baltimore, MD, 21287 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

S. Sall

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Makares James 2010 10:30P™ January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore Co. Essex Riverview Nursing Home 8. Date of Birth
(Month, Day, Year)
July 7.19 . Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. g. Birthplace (State or Foreign **Funeral** 1 x M 2 □ F Months Days Hours 213-30-6498 Mary Pand 76 Director Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD 1 Yes 2 No Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21221 1 Eastern Ave. U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian. Armed Forces? Black, White, etc. 1 X Never Married 2 Married Completed by 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation permit. Page 1 and 2 should be filed within 72 h
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "na
any injury or other traumatic event, the Medic 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 8 Laborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Makares Catherine R. Labuda August 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20 Ardisio Circle Ormand beach, FL 32174 Mary Strange / Sister 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place, HillTop Service Corp. 4 ☐ Donation 5 ☐ Other (Specify) Jan 11,2010 Towson, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. hiche 7922 Wise Ave. Dundalk, MAryland 21222 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Alyolodis Mactai Physician/ Syndrome disease or condition resulting in death) 29 PP C Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): physician and the burial-transit that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 attending p 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Pregnant at time of death Day Year signed by the a 1 ☐ Yes 2 ☐ 9 ☐ Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Coago log noty 1 Yes 2 No 3 Probably 4 Highway Completed those las dystroply. 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has death? hepertees in performed' certificate 1 Yes 2 No Yes 2 L 25. Was case referred to medica Division of Vital Hospital or Attending Physician: Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) To the Funeral Director: After the completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year, 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 No 2 Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, after determined City or Town, State) To the Hospital within 24 hours a To the Funeral I Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D19667 01-08-2010 30. Name and address of person who completed cause of death (Item 23a) Type, Print) 31. Date filed (Month, Day, Year) 32. Regist ar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		٠	1 - State Registrar		and / Depa <i>Cei</i>	rtificate of L	Death	R	eg. No. 2011	00//9
	Physici	an	Decedent's Name (First, Middle, Last)					Date of Deat Month	Day Year	3. Time of Death
	/Medic		Dorothy Mor				Leasting of Dooth	Januar		
	Examin	er	4a. Facility Name (If not institution, give s Tonns Hopkins		Medica	4b. City, Town, or	imore	1	4c. County of Dea	N/A
	Funeral		Social Security Number 6. Sex	7. Age (In yi	rs. last birthday)	If Under 1 Year	If Under 24 Hrs.		9. Bir	thplace (State or Foreign
	Director		077-20-8183	^{3 M 2 □} x ^F 82	Yrs.	Months Days	Hours Min.	(Month, Day Jan. 2]		ountry) V York
	pu »		Usual Residence of Decedent 10a. State 10b. County	100	City, Town or Lo	eation				10d. Inside City Limits
	f show	ō	. ,		Oity, Town of Lo		1 4			1 □ Yes 2 ဩNo
	28a-1	rect	MD Balti 10e. Street and Number	more		10f. Zip Code	ndalk	1	0g. Citizen of What Co	ountry?
	3a or	Funeral Director	891 Mildred Aven	ue			21222		United Sta	ates
	death	ner		12. Was Decedent Ever in	U.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (S	pecify Yes or No-	14. Race - Ame	erican Indian,
9	or ite	F.	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 □Yes 2 □ No If Yes, Give		1 □Yes 21☑No	Specify:	o riidan, etc.)	Black, Whit	e, etc.
21215-0036	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f show ont, the Medical Ex., utrust must be redified at	d by	3 ☑ Widowed 4 ☐ Divorced	Year or Dates:			-41		16b. Kind of Business.	White
15-	"nat	Completed	15. Decedent's Educ (Specify only highest grade	e completed)	(Give	dent's Usual Occup: kind of work done o DO NOT use retired	durina most of wor	king	16b. Kind of Business.	moustry
212	withi	mo l	Elementary/Secondary (0-12)	College (1-4or 5+)		Homemake			Own Hom	ie.
	al Hyg other	Be C	17. Father's Name (First, Middle, Last)			TOMEMIA		ne (First, Middle, I	Maiden Surname)	
Maryland	ges 1 and 2 should be filed within 72 hours after death with the Maryla to f Health and Mental Hyghene. If item 27 Is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examinations in a family of the fractions.	ToE	Edward Miller				Do	orothy Sm	nyth	
lar	2 sho and Is ma	·	19a. Informant's Name/Relationship (Ty)			_			r, City or Town, State,	
	1 and 2 Health em 27 l		Glenn Morelock (Transvers			River, MD	21 220
Baltimore,	ges 1 If ite or of		20a. Method of Disposition XXBurial 2 ☐ Cremation 3 ☐ R	removal from State		osition (Name of matory or other plac	i		20c. Location - City or	
별	it. Pa irtmer irtant njury		4 □ Donation 5 □ Other (Specify) 21. Signature of Wheral Service License			It. of Jes 2. Name and Addres		1/14/201	.0 Dundal	k, MD
Ba	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		21. Signature in viteral service Liberise	1/was		Duda-Ruc	k Funera	1 Home o	f Dundalk,	Inc. 21222
			23a. Patt 1. Enter the disease, or compli	cations that caused the de	eath. Do not en					Approximate Interval Between
	Physician		shock, or heart failure. List only or Immediate Cause (Final disease or condition		shirat	aru Fa	ilure			Onset and Death 48 Hours
	/Medical		resulting in death)	1		0, 9, 100	7100 -			10 110003
				Due to (or as a cons	sequence of):	Ú _		. ,		
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and the same	Examiner	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a cons	sequence of): Spirat sequence of):	ory Fa	neuma	onia		5 days
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68760,	physician and the burial-transit	dical	resulting in death) Last	Due to (or as a cons	sequence of):	tion P	neuma	onia		5 days
ox 68760,	physician and the burial-transit	dical	IF FEMALE: 23b. Was decedent pregnant	Due to (or as a cons Due to (or as a cons d.	sequence of):			onia	23d. Date of de	alivery
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 00780 State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Maryanna Reed Maguire January 2010 10:20 P™ Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Pickersgill Towson Baltimore Social Security Number If Under 1 Year I If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Country) Indiana 1 □ M 2 🖵 F Months Days Hours Min. (Month, Day, Yea D 25 **Director** 91 155-05-9580 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10b. County 10c. City, Town or Location the Maryland 10d. Inside City Limits Director 1 🗆 Yes 2 🔀 No MD Baltimore Towson 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral permit. Page 1 and 2 should be filed within 72 hours after death with 615 Chestnut Avenue 21204 USA items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. Completed by 1 Never Married 2 Married o, Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give "natural", Specify: 3 X Widowed 4 Divorced white Year or Dates It of Health and Mental Hygiene.

If item 27 is marked other than "natur or other traumatic event, the Medical! 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) **5+** Elementary/Seconday (0-12) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ James K. Reed Pearl Virginia Thompson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14 Hampshire Woods Court; Towson, MD 21204 Susan M. Spicer / daughter 20a. Method of Disposition 1 Burial 2 Cren 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 2 Cremation 3 Removal from State Important: If any injury or once. 4 Donation Other (Specify) Bee Tree Cemetery 1/15/10 Parkton, MD 21. Signature of uneral Sen 1050 York Road 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Towson, MD 21204 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one cause that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death on each line. Immediate Cause (Final Physician/ DSI disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner 1 MAV YACT week Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury Due to for as a nunsi duence of Exam and burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Day ed by the a 9 Unknown Division of Vital Records, P.O. ate has been signed by page 2 should be detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy perform 24 hours after death.

e Funeral Director: After this certificate has a filled in by the funeral director, pag 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner?
1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation Could not be Accident Suicide 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 7/2009

31. Date filed (Month,

1. Charles St. Bolo. md Zizox

30. Name and address of person who completed cause of death (Jem 23a) (Type, Print)

9

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** McMullen 3:40 a^M Robert Januarv 12, 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Lorien-Mays Chapel Timonium Baltimore 5. Social Security Number 8. Date of Birth Month, Day, NOV 7, 6 Sev 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral Months Days Hours Min. 1 JM 2 F 1926 306-24-3579 83 Indiana Director Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. Inside City Limits 28a-f shov item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Wodical Evaning must be notified at MD Baltimore Timonium 1 Yes 2X No Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or it may lijury or other traumatic event, the Medical Evantment must both once. U.S.A. 12251 Roundwood Rd., Unit 406 21093 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 DXYes 2 DNo
If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 XNo Specify þ 45-46 Specify. White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sales Retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be McMullen Raymond Katherine ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marjorie McMullen-wife 12251 Roundwood Rd., Unit 406, Timonium, MD 21093 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Dulaney Valley 1/14/10 Timonium, MD 4 □ Donation 5 ☑ Other (Specifortombment 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Funeral Service Licensee William G. Dau 1050 York Rd., Towson, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (r as a consequence of): Examiner SPIRATION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospital or Attending Physician: The law requires that the death certificate be executed EMENTIA -ALZHEIMERS physician ar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical attending p for use as IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 - Ectopic pregnancy Month Day Ye ai 5 Other (specify) signed by the a ☐Yes 2 121No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2 🗹 No 1 ☐Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 ₩ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation s after death.

I Director: A id in by the fu 1 □Yes 2 □No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide n 24 hours af e Funeral D letely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier within 24 hou

To the Funer

completely file and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed/(Month, Day, Year) D61731 al

State Registrar

N. CHARLES ST., 4165, BALTO., MD 21204 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6701

anera B.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Helen. Geraldine Muthiq January 195, 2010 9:09 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Gilchrist Towson . Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Social Security Number 212–28–4441 1 🗆 M 2 🗶 F Months Days Hours Min Country Mary land 8/29/1930 Director 79 Usual Residence of Decedent show Page 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatlth and Mental Hygiene. ant I item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits MD Harford Bel Air 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 953 Fitzpatrick Drive 21014 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 XNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White If Yes, Give Specify 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Nursing 5+ Reg. Nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Charles C. Peet Helen Mazanek 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21084 Stephanie Novak Hau / 1607 Randallwood Court Jarrettsville, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of h Important: If ite any injury or ot once. Date 1 🗌 Burial 2 💢 Cremation 3 🗌 Removal from State Hilltop Serv. Corp. 1/20/2010 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility TOWSON, Mary Tand 21204 21. Signature of Funeral Service Lice Ruck Towson Funeral Home, Inc. 1050 York Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ ongestive disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to in the late cause. Enter Underlying Cause (Disease or iinjury Examiner Dan to (or as a consequence or) Hosbital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Day Year by the 1 L Yes 2 L signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Completed cate has been signated by page 2 should b 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy After this certificate to funeral director, page performed 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 2 No 2 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of De th Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending work?
1 Yes 2 No ☐ Accident ☐ Suicide Investigation Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours atte To the Funeral Dir Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nivrau Fractioners T. The basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only or 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

State

Registrar

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 1cttol son au /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Howard Columbia **Howard County General Hospital** If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1 □ M 2 □ F Months 86 Sep 4, 1923 Director 100-18-9459 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ms 23a or 28a-f show 1 ☐ Yes 2 No Columbia Director MD Howard 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with i ment of Health and Mental Hyglene.
ant: If item 27 15 marked other than "natural", or items 23a or i ury or other traumatic event, I'm Medical Exon. Inc. 1. 21044 U.S.A. 5400 Vantage Point Rd. #205 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cyban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 1 Never Married 2 Married 1 □Yes 2 No Specify. þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Fabiene Laurencelle Leo Gerard Kney ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health an Important: If item 27 Is any injury or other trau 4830 Castle Bridge Rd. Ellicott City, MD 21042 Susan Coursey daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Feb 05, 2010 Arlington, Virginia 4 ☐ Donation 5 ☐ Other (Specify) Arlington National Cemetery 21. Signature of Funeral Source Licensee 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on such line. Immediate Cause (Final disease or condition resulting in death) Ulmorak Physician /Medical Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 mor Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Ves 2 No 1 ☐ Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Mann of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 Pending 1 □Yes 2 □No 2 Accident investigation 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Examiner or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Division of Vital Records, P.O. Box 68760 attending p for use as t cate has been signed by the page 2 should be detached this certificate funeral director, within 24 hours after death.

To the Funeral Director: A completely filled in by the fu To the Hospital

the Maryland

Baltimore, Maryland 21215-0036

State

Registrar DHMH 17 Rev 1/2001

Medical

SOOPEMOXY 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

4 SUITE 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29a. Certifier

(Check only one)

1🗹 Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

KENK

BALTIMORE

29d_Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
 Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ JANUARY 13-37M 2010 Jacqueline J. Newman Medical 4c. County of Death **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death GOOD SAMARITAN HOSPITAL BALTIMORE 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 X F 74 Days 12-12-1935ar) Mary rand Director 219-32-7654 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director Maryland N/A Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7711 Windy Ridge 21236 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. δ 1 Never Married 2 X Married If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: Completed 3 Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Book Keeper Grocery Business Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Benny Mangione Agnes Cataldo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Deborah Heilman - Daughter 3603 Advocate Hill Road Jarrettsville, MD 21084 Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Most Holy Redeemer Cem. 01-21-2010 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Se //e Ligensee 22. Name and Address of Facility 5305 Harford Road Leonard J. Ruck, Inc. Baltimore, Maryland 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ DNGESTIVE disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner DRONARY Secreptially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☑ No
9 ☐ Unknown Month Dav Year 9 Unknown signed by the P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2; No 3 Probably 4 Unknown Division of Vital Records, 1 🗌 Yes icate has been significate has page 2 should t 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? Yes 2N No death? certificate 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) eral Director: After this filled in by the funeral di 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 10 Natural 5 Pending 1 Yes 2 No 2 Accident 3 Suicide Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral C

completed filled Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in this popular, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number RES-000 forth 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GOOD SAMARI TAN HOSFITAL 5601 LOCH RAVEN BLVD BALTIMORE 21239 31. Date filed (Month, Day State Registrar

アンタン

State of Maryland / Department of Health and Mental Hygiene 0 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 8:50 P M January P5, 2010 Katherine A. Natale Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Examiner Cockeysville Labrador Lane 9607 Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country)Maryland 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 🗆 M 2 🔀 F Days Min. 9425 14938 212-38-4994 71 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🛛 No Cockeysville Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21030 9607 Labrador Lane Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Race - American Indian Black, White, etc. 11. Marital Status Armed Forces? Š 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify: Specify: White Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry College (1-4 or 5+) Elementary/Seconday (0-12) Nursing Reg. Nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Una Mullin Harvey Moore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anthony P. Natale / Husband 9607 Labrador Lane Cockeysville, MD 21030 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🗓 Burial 2 🗆 Cremation 3 🗆 Removal from State Garrison Forest Cem. 1/26/2010 Baltimore, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral 22. Name and Address of Facility Towson, Maryland 21204 Ruck Towson Funeral Home, Inc. 1050 York Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Dupre. Medical Due to (das a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Pregnant at time of death 1 ☐ Yes 2 ☑ No 9 ☐ Unknown g Unknown P.O. | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Records, 1 ☐ Yes 2 ☐No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 Yes 2 No Yes 2 N Division of Vital Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \square Nursing Home 5 \blacksquare Residence 6 \square Other (Specify) 2 **N** No ٩ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of Certificate: 28d. Describe how injury occurred work? 1 🗆 Yes 2 🗆 No 1 Natural 5 Pending 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signat and title of certifier 29c. License number D20649 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE, MD. 21204 ST. #4902 CHARLES , M.D. 6701 BOWIE N. 31. Date filed (Month, Day, Year) -32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
amend #12,17&dat Per Mary and Department of Health and Mental Hygiene
Amend Item 25 per me, g902,04705/2010dhb, 253a Certificate of Death Decedent's Name (First, Middle, Last)
 FRED 2. Date of Death **NEUBERGER Physician** JANUARY 15, 2010 2:45 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner LEVINDALE HEBREW HOME N/A BALTIMORE 7. Age (In yrs, last birthday, If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign Country) **Funeral** 1**X**M 2□F 07/01/1926 Yrs. GERMANY 218-26-2185 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or Items 23a or 28a-f show 10c. City, Town or Location 10b. County 10d. Inside City Limits notified at 1 X Yes 2 ☐ No Directo MD BALTIMORE N/A 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Item 27 is marked other than "natural", or Items 23a or other traumatic event, the Medical Examiner must be in 2903 FALLSTAFF ROAD, #306 21209 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

12. Was Decedent Ever in U.S. Armed Forces?

14. Was Decedent Ever in U.S. Armed Forces?

14. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 WHITE 1 ☐ Yes 2 🕅 No Specify à Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) SALES Elementary/Secondary (0-12) 12 College (1-4or 5+) INSURANCE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ado1f **UNKNOWN** NEUBERGER Frohlich MIRIAM **UNKNOWN** 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3107 PARKINGTON AVENUE, BALTIMORE, MD 21215 REBECCA HOROWITZ / PERSONAL REP 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If Ite any injury or ot 1X Burial 2 □ Cremation 3 □ Removal from State CHEVRAY AHAVAS "CHESED 01/17/2010 ROSEDALE, MD 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licen 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that it is sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Sepsis Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ostevny elitis Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed 1 Manobalit attending physician and for use as the burial-tra Due to (or as a consequence of) Box 68760, complications Physician/Medical ERTIFICATION as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? Month Day Year 4⊡Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f ☐Yes 2☐No Division or Vital Records, P.O. 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ failure Anemia 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed fibrillation Mcel nu trition (MALABSOR Ption) 24a. Was an Atricul 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1☐ Yes 2 No Division or Vital

Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medical examiner?

1 XYes 2 1 director Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manne of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 🗌 Yes 2 🗆 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the within 2 and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D3037 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6503 PARIL HEIGHTS AVE BALT MID ZIZIS Robert M. Cooper W 31. Date filed (Month, Day, 32. Registrar's Signature Year) State Registrar

00787 State of Maryland / Department of Health and Mental Hygiene 2 State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month January 2010 O'Neill, Sr. 6:55 A ^M Charles Joseph Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Gilchrist Center Towson 5. Social Security Numbe 6. Sex 1 🛣 M 2 □ F If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Day, Year) h 14,1941 Days Hours Min. Months Month. Director Ohio 299-34-9767 68 March Usual Residence of Decedent show ms 23a or 28a-f shor must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 Yes 2 X No Baltimore Cockeysville Maryland 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? Funeral 21030 USA 6 A Nutmeg Knoll Court Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or iten ledical Examiner n 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black White etc. 1 Never Married 2 Married ģ Maryland 21215-0036 1 ☐ Yes 2 👿 No Specify: Specify: Completed 3 Widowed 4 X Divorced White the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) I Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) 12 04 <u>Salesman</u> Computer/Printing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t. Page 1 and 2 should be filed tment of Health and Mental H rtant: If item 27 is marked ot njury or other traumatic even ည 0'Nei11 John Ε. Marv Louise 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph Charles O'Neill, Jr. /Son 18315 Neff Road, Cleveland, Ohio Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🌠 Cremation 3 ☐ Removal from State permit. Page Department Important: I any injury o 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 1/15/10 Glen Burnie, Maryland 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley Inc.
Lemmon Funeral Home of Dulaney Warvland 21093 Signat Bryan W. Clary 10 W. Padonia Road. Timonium. Marvland 23a. Part 1. Enix r the lisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate (ause (F) al Ph sician/ disease or c directly resulting in death) conce Wenths Medical o (or as a con a quence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Exami or Attending Physician: The law requires that the death certificate be executed the burial-transi this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Pregnant at time of death 5 Other (specify) Day 9 Unknown 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 X Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 25. Was case referred to medical examiner? completed filled in by the funeral director, B 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 A Other (Specify) WSAL 2 No ည 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) . Manner of Dea Certificate: 28b. Time of 1 Natural 28c. Injury at work? 1 ☐ Yes 2 ☐ No After t 28d. Describe how injury occurred injury 5 Pending Accident Investigation within 24 hours after deatl To the Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Charles VI WIT W 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Amend Items 20b per dvr., g899; 61419429194hb Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 1:20 A M JAN 2010 bhala /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** HOSPITAL BALTIMORE AGNES 9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, **Funeral** Days Hours Min. 1 NM 2 F 76 Yrs. 214-30-2928 December Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10h County 10c. City, Town or Location 10a State 28a-f show ?? is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Madical Examinar must be notified at 1 Tes 2 No 0. Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number SE onumenta 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 72 hours after 1 □Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Maryland 21215-0036 Specify Specify: þ 3 Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NQT use retired) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be မှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important; If item 27 is t
any injury or other trautonce. Halethorpe/ND 21222 Monumer Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 01/16^{Date}2010 20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Removal from State Meadowriage 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 4600 10 2120 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician SUBDURAL HEMATOMIA disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner DAYS ACCIDENT CEREBROVASCULAR Se prentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner burial-trar Due to (or as a consequence of): the attending physician P.O. Box 68760 Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day for in the past 12 months? 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown signed by t d be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 3 Probably 1 □ Yes 2 □ No CANCER page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 2 No 2 No 1 ☐ Yes 1 □Yes Hospital or Attending Physician; 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1- Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 2 Accident the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Lecrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier JAN, 09, 2010 M.D P23148 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE 21229 RAJANI JAGANA, SE AGNES HOSPITAL, 900 SOUTH CATON AVENUE. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JAN 1 9 2010

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Yea Month Physician/ 2010 Medical cility Name (if not institution, give str County of Deat City, Town, or Cocation of Death Examiner RUNde enter FIEN NNE 9. Birthplace (State or Foreign 8. Date of Birth Age (In yrs. last birthday) 1 Year **Funeral** Min. 02/1971926 1 🕅 M 2 🗆 F 235-38-8301 83 Virginia Director Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10c. City, Town or Location If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 🖾 No Anne Arundel Co Glen Burnie Maryland 10f. Zip Code 10g. Citizen of What Country? 21061 Completed by Funeral 603 W. Furnace Branch Road Id be filed within 72 hours after death with Mental Hygiene. United States 12. Was Decedent Ever in U.S. Armed Forces?

1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates. WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married ☐ Yes 2 No Specify. Specify: White 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Printing 12 +1<u>Printer</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Owens Rufus Pippin Frances .. Page 1 and 2 should b tment of Health and Mer tant: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Thelma Pippin / Wife 603 W. Furnace Branch Road Glen Burnie, MD 21061 Baltimore, 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1
Department of I
Important: If it
any injury or o emetery, crematory or other place) MD Veterans Cemetery | Crownsville, Maryland 01/26/2010 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Singleton Funeral & Cremation Signature of Funeral Service Licenses M01121 MD 21061 Services PA; 2nd Ave SW 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter orderlying Cause (Disease or iinjury Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 - Fetal death Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day 5 Other (specify) Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No Yes 2 1 No 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 2 🗹 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation Accident Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 V MISTAR DMONG aur 67 31. Date filed (Month, Day, Year) egistrar's Signa State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ January 2010 Ellen Pieters 7:45P M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City. Town, or Location of Death Glen Burnie Health Rehabilitation Glen Burnie Anne Arundel Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days March 12,1925 1 □ M 2 🕅 F Hours PA Director 219-10-3722 84 Usual Residence of Decedent show 10a. State 10b. County 10c, City, Town or Location the Maryland notified at 10d. Inside City Limits Director 28a-f MD Anne Arundel Glen Burnie 1 Yes 2 No 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? other traumatic event, the Medical Examiner must be Funeral with 23a 21060 219 Ditty Court U.S.A. items , Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 XNo Black White etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) School Cafeteria Baker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ೭ Leslie Williams Louise Sorge 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Johannes Pieters / Husband 219 Ditty Court Glen Burnie, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Department of I-Important: If ite any injury or oti 1 M Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Mem. Park 01-21-2010 Glen Burnie, MD 21. Signatore of Funeral Service 22. Name and Address of Facility 1 2nd Avenue SW Glen Burnie, MD Singleton Funeral & Cremation Services, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Pnysician/ disease or condition resulting in death) envo Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions. if any leading to immediat cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav Year Pregnant at time of death 5 Other (specify) signed by the a d be detached f g 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Pulmonary cate has been sig page 2 should b 2 No 3 Probably 4 K Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☑ No completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 45 Nursing Home 5 Residence 6 Other (Specify) 2 X No ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury 1 Yes 2 🗆 No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1- Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

State

Registrar

DHMH 17 Rev 7/2009

only one) 29b. Signature and title of certification

31. Date filed (Month

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

tmbalavanar

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29d. Date signed (Month, Day, Year)

alen Rurna

29c. License number

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Oakwood Road

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death JMMJARY Dayl. 5 , Mary Louise Pasko Physician/ Medical 4a. Facility Name (if not institution give street and number). 4b. City, Town, or Location of Death 5 0 Th 4c. County of Peath timore **Examiner** Center If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Funeral Social Security Number 216-20-0917 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign (Month, Day, Nov • 28 81 1 □ M 2 🗓 F Months Days Hours Director 1928 Maryland Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Parkville MD Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21234 2604 Crabapple Road U.S.A. Funeral 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 X No Black, White, etc. 1 Never Married 2 Married <u>م</u> 1 ☐ Yes 2X No Specify: Hygiene. other than "natural", If Yes, Give Specify: White 3 XWidowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 1 2 Insurance College (1-4 or 5+) should be filed with and Mental Hygien 7 is marked other the Vice President Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ James Chambers Catherine Wagner and 2 should be Health and Meretem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3101 Clearfield Court, Baldwin, MD 21013 Jane Schroeder/ Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any Injury or ot 1 X Burial 2 Cremation 3 Removal from State Parkwood Cemetery 01/19/10 Parkville, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22 Name and Address of Facility Evans Funeral Chapel & Cremation 8800 Harford Rd. Parkville, MD 21 2 ia. P. 11. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shirck, or heart failure. List only one cause on each line.

In me, ate Cause (Final CORONARY ARTERY DISEASE Approximate Interval Between Onset and Death Physician/ di e or condition resulting in death) Medical Duf SCREMIC COLITIS Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to for as a consequence on and -transit death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of). attending physician a for use as the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 📉 No 5 Other (specify) Month Day Year 1 Yes 2 9 Unknown signed by the a t II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ${ t DIABETES}$ ${ t MELLITUS}$ 23e. Did tobacco use contribute to the cause of death? 2 Completed 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of cate has bage 2 s autopsy performed death? certificate 2 No Hospital or Attending Physician: 25. Was case referred to medical director, Be 26. Place of Death (Check only one) examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 1 🗌 Yes 2 No ျှ 1 Inpatient 2 Inpatient 3 Inpatient 2 Inpatient 3 Inpatient 2 Inpatient 3 Inpa this 28a. Date of injury (Month, Day, Year) within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral 27. Manner of De h Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending work 1 Yes 2 🗌 No Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 🗆 Homicide determined City or Town, State) Medical 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number la mi D0041410 2010 Jahuar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JUGINDER P. MEHTA. 7601 OSLER DRIVE TOWSON, M. D.

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

Maryland 21215-0036

Baltimore,

Box 68760

P.O.

Records.

Division of Vital

32. R. gistrar's Signature

MARYLAND

21204

10-00203
Francine D Pugh

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ancine D Pugh		1- For State	of Maryland /		artment of rtificate of		d Menta	al Hyg		aa Na	201	n	n	0793
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Funeral Director		5. Social Security Number 6. 8 216-78-8855	Sex 7. Age	(In yrs. I	ast birthday) Yrs.	If Under 1 Year Months Days			8. Date of Bir					
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the Mar 3a or 28a	Director	12 S. Bernice	Avenue			21229				USA		ountry	, :	
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~ 2 0 3 +	-	Janice Rawling	s/ Siste	r	12 S.	Berni	ce Av	enu	e Bal	tim	ore,M	lar	ylar	nd
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Baltimo permit. Pag Department Important: injury or of	Ц	21. Signature of Finer V Service Lice			22. N	ame and Address	of Facility	hat	man-H	arr	is Fu	ne	ral	Home
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876 tificate ng phy as the b		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcom	e of preg		aldeath 3 [Ectopic p	oregnand	су		. Date of deliv Month	very Day	,	Year
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Division of Vital Records, spital or Attending Physician: The law requirence after death. Peral Director: After this certificate has been sfilled in by the funeral director, page 2 should	Certification:	3 Suicide 6 Could no determine		ury - At he	ome, farm, stree	t, factory, office b	uilding, etc.	2	8f. Location (S or Town, S		id Number or	Rural	Route No	umber, City
Division of Vital F To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certificompletely filled in by the funeral director,		29a Cartifier	cian: To the best of my											
To To I	Medical	29b Signature and title of certifier	and manner stated.			29c. Licens					Date signed (ar)
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K		30. Name and address of person who Carol Allan, MD Assist.	completed cause of de ant Medical Exam	-		treet, Baltime	ore, MD 2	21201						
St Regist	ate rar	31. Date filed (Month, Day, Year)	32. Registrar	's Signatu	. bar	Ke								
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DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Carmela R. Prodey MAL 3:00 PM 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner BALTIMORE WASHINGTON MED UR 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) G LEM BURNER If Under 1 Year | If Under 24 Hrs. AHME ARUNDEL 8. Date of Birth (Month, Day, Yes June 20, Birthplace (State or Foreign Country) **Funeral** Year) Months Hours 1 □ M 2 □ F Days Min. Director 214-26-2507 80 MĎ 1929 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Dipartment of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evantment be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director MD Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 180 Riviera Dr. 21122 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No Specify white Completed by 3 ₩ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 n/a Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Anthony Longo ပ Angeline Catanzaro 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hilaria Thompson/daughter 1316 Gatwick Rd., Glen Burnie, MD 21061 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Holy Rosary Cemeterly 1/19/10 4 Donation 5 Other (Specify) Balto., MD 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley,
10 W. Padonia Rd., Timonium, MD 21093 21. Signature of Funeral Service Inc. Nagle 23a. Part 1. Enter the disease, or on plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** DATS EREBROVAS CULAR disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 7 PERTENSION TEARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of a The law requires that the death certificate be executed and the burial-tran Due to (or as a consequence of) 68760 physician Physician/Medical as the attending for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ∐Yes 2 🖼 tijo detached o 9 II Unknown ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ð director, page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 1 ☐ Yes 2 ☐ No 1 □Yes 2\ Division of Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1☐ Yes 2☐No 1 ER/Outpatient 3 DOA Certification: To this Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? After 1 28d. Describe how injury occurred or Attending Natural 5 Pending death. 2 Accident investigation 1 ☐ Yes 2 ☐ No after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral L Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State

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31. Date filed (Month, Day, Year)

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DHMH 17 Rev 1/2001

Registrar

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DR

HOSPITAL

Earne, ms

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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-BONNE

13/2010

CIEN BURNE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** an varu Francis F. Pulaski /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner a quare Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yes **Funeral** Days Hours Min Months 1**™** M 2□ F 214-26-5890 8Ď 12-5-1929 Director MD Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or items 23a or 28a-f show 10d, Inside City Limits 10c. City, Town or Location 10b. County 10a. State Item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examinar must be notified at 1 X Yes 2 No Director MD Baltimore Middle River 10g. Citizen of What Country? 10e, Street and Numbe 10f. Zip Code 7516 Schooner Lane 21220 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 □Yes 2 No If Yes, Give Year or Dates: Korea 2 Specify white 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Tractor Operator <u>Bethlehem Steel</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Felix F. Pulaski ဥ Patronella Ciosek 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anna Pulaski - Wife 7516 Schooner Ln., Middle River, MD 21220 Department of Healt Important: If Item 2 any Injury or other once. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Bayview Crematory 1-13-10 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Bradley-Ashton Funeral Home Willow Spring Road, 21222 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final er **Physician** 0 disease or condition resulting in death) /Medical Due to or as a consequence of) Examiner Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine -transit been signed by the attending physician and should be detached for use as the burial-trar resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) 1 ∐Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? 1 ☐ Yes 2 ☑ No certificate 1□Yes 2□No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

executed Division of Vital Records, P.O. Box 68760, or Attending Physician: The law requires that the death certificate beather death. To the Funeral Director: After this certific completely filled in by the funeral director, Hospital 24 hours a

Itimore, Maryland 2121

State Registrar

SAJID ARVAIN

and manner stated

29c. License number

29d, Date signed (Month, Day, Year)

30. Name and address of person w

000 Frank

32. Registrar's Signature 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

To the within 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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ಲ		4a. Facility Name (if not institution, give street and number 42 Midway Avenue	r)	4	b. City, Town, o	r Location o		•	4c. County of Howard	Death	
Funeral Director		5. Social Security Number 006-68-2156 6. Sex 1 M 2 F	nge (In yrs. Ia 51	st birthday) Yrs.	If Under 1 Ye Months Da		Min.	3. Date of Birt	1958	9. Birthpla Foreign R Country	node Island
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th the Maryland 23a or 28a-f show notified at once.	Director	Maryland Howard 10e. Street and Number		aurel	10f. Zip Code			10	g. Citizen of Wha		Yes 2 X No
vith the Ns 23a or 2 anotified		42 Midway Avenue 11. Marital Status 12. Was Decede	nt Ever in U.S	S 13 Way	20723 s Decedent of H	isnanic Orio	in? / Speci	fy Yes or No-	USA	American	Indian, Black,
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21215-0036 Juld be filed within 7 Mental Hygiene. marked other than e event, the Medica	å	17. Father's Name (First, Middle, Last) Henry Andrew Pogorzelski							laiden Surname) / đ		
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other transmarts.		20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from 4 Donation 5 Other Specify:		verview (1/20,	/2010	20c. Location - 0 Orono Ma	ine	n, State
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Physician /Medical Examiner		23a. Part I. Enter the disease, or complications that cause failure. List only one cause on each line. Immediate Cause (Final disease a Acute Corona			ne mode of dying	g, such as ca	ardiac or re	spiratory arre	est, shock, or hear		pproximate Interval letween Onset and Death
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Divisior To the Hospital or Attend within 24 hours after death to the Funeral Director completely filled in by the	ertification:	2 Accident Investigation	Injury - At ho	ome, farm, stree	et, factory, office			f. Location (S or Town, St		or Rural f	Route Number, City
To the Hospi within 24 hour To the Funer completely file	ة ا	29a. Certifier 1 Certifying Physician: To the best of (Check only one) 2 Medical Examiner: On the basis of early manner state	camination ar								use(s)
	Me	29b. Signature and title of certifier	1			.M.E.			29d. Date signed January 14,		Day, Year)
3V		30. Name and address of person who completed cause of Zabiullah Ali, M.D. Assistant Medical	1	ľ	n Street, Ba	ltimore, N	/ID 2120	1			
Stat	te	31. Date filed (Month, Day, Year) 32. Regis	rar's Signatu	re &	hall	,			-		

DHMH 17 Rev 1/2001 OCME 2006 OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year 0938 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore University of Maryland Center Medical 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 XM 2 | F Months Days Hours Min. (Month, Day, Director 0-04-796 35 Usual Residence of Decedent works / 10a. State 10b. County 10c. City, Town or Location with the Maryland Examiner must be notified at 10d. Inside City Limits Director 28a-f 1 XYes 2 ☐ No Baltimore 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 200 42c death v 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Black, White, etc. 1 Never Married 2 Married ò þ Yes 2 No within 72 hours after Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify: If Yes, Give Year or Dates "natural" Specify Completed 3 Widowed 4 Divorced White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 19 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 permit. Page 1 and 2 should be I Department of Health and Menta Important: If item 27 is marked traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Fural Route Number, City or Town, State, Zip Code) Baltimore, Manor Ave MDalaco Baltimore, other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State injury or 4 Donation 5 Other (Specify) Cremitori 21. Signatural new Service License 22 Name and Address of Wility 13.30 Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Intracerebra Subarachnoid Hemosthane disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner 4 years Glioblestour Multifoca Sequentially hat conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Day Year the page 2 should be detached 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 | Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an certificate has performed? Yes 2 No 1 ☐ Yes 2 ☐ No Vital the fune al director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 X Yes Hospital 2 🗌 No Other: 2 1 ► Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) of 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Hospital or Attending **X**Natural 5 Pending Division _____atural
☐ Accident
☐ Suic 1 Yes 2 No Investigation 24 hours after deat Funeral Directors 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office in by 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) completed filled Medical 29a. Certifier trifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Signature and title of certifie 29d. Date signed (Month, Day, Year) 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bultimore Greeve St. Kenneth Crandall, 21201 22 32. Re State

ORIGINAL

Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death **Physician** Year Jan nen Frances Barbara Reed 12010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner len Burni Baltimore Washington Medical Center Anne If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) Funeral Months Days 214 22 3613 Director 83 Oct.12, 1926 Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 28a-f show 10c. City Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f shov Examiner must be notified at Director 1 ☐Yes 2 ☑ No Baltimore Maryland | Essex 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 Brett Ct. Apt. 211 21221 USA death v Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Was ⊔ecedo... Armed Forces? 1 ∐Yes 2 ☑ No Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 'natural", or þ 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Health and Mental Hygiene. Homemaker 12 Own Home is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frank Bauer ပ Margaret Schinnick 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health an Important: If item 27 is any Injury or other trau Janet A. Hayes (Daughter) 1736 Poplar Ridge Rd. Pasadena, Maryland 21122 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Burial 2 ☐ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gardens Of Faith Cemetery 1/22/2010 Baltimore, Maryland 22. Name and Address of Facility
Bruzdzinski Funeral Home P.A. 21. Signature of Funeral Service Licenses 1407 Old Fastern Avenue Essex, Maryland 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) flust **Physician** /Medical Due to (or as a consequence of) Examiner X Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760 Physician/Medical yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Year Day Pregnant at time of death 5 ☐ Other (specify) the detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Š cate has been sign page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performe certificate death? of Vital 1 ☐ Yes 2 🗖 No 2 N/0 Hospital or Attending Physician: completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No မ 1 pinpatient 2 ER/Outpatient 3 DOA after death. 27. Manner of Death Date of Injury (Month, Day, Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1-Natural 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 29a. Certifier 🖎 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29b. Signature and title of certifi 29c. License number 29d. Date signed (Month. Dav. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) h

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day,

32. Registrar's Signature

10-00391 James Rayman Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ames Rayman		State of Maryland / Do		tment of ificate of		and	Menta	al Hyg			20	10	0070
Physicia		Registrar 1. Decedent's Name (First, Middle,Last)			Deaur				2. Date of Dea		20	14	3. Time of Death
Medical Examir									Month January 1		Year 0		1829 hrs
		4a. Facility Name (if not institution, give street and number)		- 4	4b. City, Tow		ocation of (Death		4c. (County of		
Funeral		Rt.40 @ Middle River Road 5. Social Security Number 6. Sex 7. Age (In	vrs las	et hirthday)	Middle I		If Under 2	24Hrs	le Date of Riv	- 1	altimore		nty place (State or
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wany	Ī		. City, To	own or Location		- 1 L				-			10d. Inside City Limits
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ا الله الله الله الله الله الله الله ال	Director	10e. Street and Number 9615 Pulaski Highway			10f. Zip Co	ode 220			1	0g. Citize	en of What USA	t Countr	γ?
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or iter	Funeral	1 Never Married 2 Married Armed Forces? 1 Yes 2 X	No	If Ye	es, specify C	Cuban, N	Mexican, P				White,	etc.	
rs after ural",	اھ	Widowed 4 X Divorced It Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade complete			Yes 2 X			-1 1 10			Specify:		ite
72 hour	eted	Elementary/Secondary (0-12) College (1-4 or 5+)	3a) '	16a, Decedent during mo	rs Usual Oc ost of workin					16b, Kir	ind of Busir	ness/Ind	dustry
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filed v Hygir of other		17. Father's Name (First, Middle, Last)				18			First, Middle, M		Jurname)		
212. uld be Menta marke	To Be	Andrew L. Rayman Jr. 19a. Informant's Name/Relationship (Type, Print)	-	19b. Mailing	Address (Street a	Joy and Number		Besser ral Route Num		or Town	Ctate	Zin Coda)
MD and 2 shoulth and 1 is a rumatic	-	Joyce Dobry / Mother	1						Baltimo				
nore, MD 21215-0036 ages 1 and 2 should be filed within 72 nt of Health and Mental Hygiene. it: If item 27 is marked other than 'other traumatic event, the Medical		20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State		ace of Disposi ematory or oth	ition (Name				Date				own, State
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Baltimore, MD 21215-00; permit. Pages I and 2 should be filed withi Department of Health and Mental Hygiene Important: If item 27 is marked other it injury or other traumatic event, the Med		21. Signature of Funeral Service Licenset Dorota Mar:	sha]	22. N	ame and Ad Maryl	dress of	f Facility Crem	— atio	on Serv	rices	5		
Physician	1	23a. Part I. Enter the disease, or complications that caused the d	death. C		PO Ro	v 1/	412	Ralt	Limoro	MD	2120	3	Approximate Interval
/Medical	g)	failure. List only one cause on each line. Immediate Cause (Final disease a Multiple Injuries								=-1			Between Onset and Death
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	اة	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequent or ce of):									-		
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ox 68760, ath certificate be ex attending physician or use as the burial	₩.	IF FEMALE: 23b. Was decedent pregnant in the 1 □ Live high	pregna				1 _{e-1-20}	1177			Date of de		
X 6876 th certifical ttending ph	icia	past 12 months?	of deat	<u>, - = </u>	al death ner <i>(Sp</i> ec <i>ify)</i>		∫Ectopic pi	regnand	ey .	iv	Month	Da	y Year
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Division of Vital Records, P.O. Box 6876. To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the tentral director.	<u></u>	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month Day Year) Jan 13, 2010		28b. Time of In 1824 hrs	jury 28c.		at Work?	lp:	8d. Describe h edestrian s			j	
iSior Attender death	<u>icat</u>	2 Accident Investigation 28e Place of Injury			t factory of		s 2 V No	10				22 Pure	Deut-Mumbor City
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e Hosp 24 ho e Fune etely f		29a. Certifier (Check only) Certifying Physician: To the best of my known	owledge,	, death occurr	ed at the tim	ne, date	and place	e, and du	ue to the caus	se(s) and	manner as	s stated	 I.
To the Howithin 24 h To the Function	Medical	one) 2 Medical Examiner: On the basis of examination and manner stated.	ion and	or investigati	on, in my op	oinion, d	leath occur	rred at t	he time, date	and place	e, and due	to the	cause(s)
	2	29b. Signature and title of certifier	1/_			icense r							h, Day, Year)
1.7	-	30. Name and address of person who completed cause of death	/Itam 2	221		D.C.M.	Е.			Janua	ary 14, 2	2010	 .
{ V		Zabiullah Ali, M.D. Assistant Medical Exami		111 Pe nr	n Street, i	Baltim	nore, ME	2120	01				
Sta Registr		31. Date filed (Month, Day, Year) JAN 19 2010 32. Registrar's Sig	gnature										
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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Josephine Robinson January 15, 2010

Physician /Medica Examine

1 - For State Registrar

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, it is Michael Evarrum. I sust by Incitified at once.

Baltimore, Maryland 21215-0036

Physician - /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

r		If not institution, give			4b. City, Town, or Location of Death Sykesville				4c. County of Death Carroll		
		Woods Nur									
	5. Social Security N	- 1	ex 7.Age □M25xTF	e (In yrs. last birthday) Yrs.	If Under 1 Year Months Day		. (Month, D	rth ay, Year)	9. Birth	nplace (State or Foreign untry)	
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Completed by Funeral Director	10e. Street and Nu	mber			10f. Zip Code)		10g. Citizen of V	What Cou	untry?	
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cations	1 ☑ Natural	5 ☐ Pending investigation	(Month, Da	v, Year) Injury		juryat ork? □Yes 2□No	Zou. Describe	riow injury occur	reu		
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=	4 ☐ Homicide	determined	building, etc	c. (Specify)			City or To	wn, State)	707 07 710	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
Medical Cerilli	29a. Certifier	1 ☐ ertifying Ph	ysician: To the best	of my knowledge, dea	th occurred at the	time, date and place	toe, and due to the	e cause(s) and m	anner as	s stated.	
2	(Check only one)	2☐ Medical Exam	iner: On the basis o and manner sta	f examination and/or in	nvestigation, in m	y opinion, death occ	curred at the time	, date and place,	and due	to the cause(s)	
ME	29b. Signature and	title of certifier	1 //		29c. Lice	nse number		29d. Date signe	d (Monti	h, Day, Year)	
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State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** amirez 8010 P u 01 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore VA Rehab and Care Center Baltimore 8. Date of Birth (Month, Day, 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1 ★ M 2 □ F 54 213-62-9236 December 10,1955 Maryland Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10d. Inside City Limits 10b. County 10c. City. Town or Location 10a State ral", or items 23a or 28a-f show Exercitive round be notified at 1 XYes 2 No Directo Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3900 Loch Raven Boulevard 21218 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No 1973— If Yes, Give Year or Dates: 1977 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: þ Specify: White 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Various Businesses Warehouseman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George Peter Ramirez Shirley Jean Lake ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 204 Mulberry Lane, Baltimore, Maryland 21220 Morgan H. Massaker/ Brother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) January 15, Department of Important: If it any Injury or o once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 2010 4 □ Donation 5 □ Other (Specify) Baltimore, Maryland Metro Crematory, Inc. 21. Signature of Funeral Service Licensee Amanda Heaston 22. Name and Address of Facility Cremation Society of Maryland, Inc 299 Frederick Road, Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** ono disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury he burial-tran that initiated events resulting in death) Last and Due to (or as a consequence of) ettending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🗆 Ectopic pregnancy Month Year 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 2 Completed

law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, cate has page 2 s

3altimore, Maryland 21215-0036

Phys	9 ☐ Unknown	3 - OTRIOWIT	
ed by PI	Part II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ 40 3 ☐ Probably 4 ☐ Unkno
Complet			24a. Was an autopsy performed? 1 \[\superset \text{Yes} \frac{24b}{b}. \] 24b. Were autopsy findings availa prior to completion of cause death? 1 \[\superset \text{Yes} 2 \] 1 \[\superset \text{Yes} 2 \] 1 \[\superset \text{Yes} 2 \]
Be	25. Was case referred to medical	26. Place of Death (Check only one)
9	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home	e 5 ☐ Residence 6 ☐ Other (Specify)
Ë	27. Manner of Death 1 ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day, Year) Injury Work?	d. Describe how injury occurred
Certificatio	3 ☐ Suicide 6 ☐ Could not 6 4 ☐ Homicide determined		f. Location (Street and Number or Rural Route Number, City or Town, State)
dical		hysician: To the best of my knowledge, death occurred at the time, date and place, an miner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	

29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Indren

31. Date filed (Month, Day, Year)

32. Registrar's Signature

29b. Signature and title of certifje

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** January 17 2010 11:52 p^M Michael Charles Ruby /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Dove House Carroll Westminster | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | April 11, 1970 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 3M 2 ☐ F Maryland 39 219-66-2876 Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10a. State 10b. County ed other than "natural", or items 23a or 28a-f show event, the Medical Examinat must be nutified at 1 Yes 2 No Carroll Directo Manchester Maryland 10g. Citizen of What Country? 10f Zin Code 10e. Street and Number 21102 United States 4914 Roller Road Funerai Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. I∐Yes 2 TxNo 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 Yes 2 XNo Specify: þ White 3 ☐ Widowed 4 🙀 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Heavy Equipment Operator Painting GED 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Kenneth W. Ruby Carolynn C. Berry ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4914 Roller Road, Manchester, Maryland 21102 Carolynn C. Ruby/ Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition January 18, Important: If it any injury or o once. 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 2010 Baltimore, Maryland * 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 21. Signature of Funeral Service Licensee Amanda Heaston 22. Name and Address of Facility Cremation Society of Maryland, Inc 299 Frederick Road, Baltimore, Maryland 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine and I-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): ed by the attending physician a detached for use as the burial-Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) TYAS 2 No 9 Unknown cate has been signed by page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part It. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 2 🗆 No certificate 2**X** No 1 TYes 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: $4 \square$ Nursing Home $5 \square$ Residence $6 \square$ Other (Specify) Hospice Certification; To 1 ☐ Yes 2X No 1 Inpatient 2 ER/Outpatient 3□ DOA After this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funerel Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 3 Suicide filled in by 4 Homicide 29a. Certifier 🗶 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and U 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) West minuty MD 21159 DR. Raman Drive, Malcalm 349 Kanera #82. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of	Marylar		artment of H rtificate of		nd Mental Hy	giene 0	10	008	02
•	Physici	an	1. Decedent's Name (First, Midd	le, Last) Romk	DNE	,			2. Date of De Month	Day	Year	3. Time of	
X.	/Medio Examir		4a. Facility Name (If not institution	n, give street and numb			4b. City, Town, o	r Location of 1	Death		ty of Death	11 (
* 1	Funeral Director		5. Social Security Number 108–03–4109		Age (In yrs.	last birthday) 3 Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Hrs. 8. Date of Bi Min. (Month, D. April]	0,1916	9. Birthp Cour New	olace (State ontry) York	or Foreign
	uit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland ariment of Health and Mental Hygiene. ortant: if itam 27 is marked other than "natural", or items 23s or 28s-f show njury or other traumatic event, it e Modical Extentiver must be notified at signification.	Funeral Director	Usual Residence of Decedent 10a. State 10b. County Maryland 10e. Street and Number 6206 Satinwood Dr. 11. Marital Status	ard		ty, Town or Lo	10f. Zip Code 21044	Hispanic Origin	n? (Specify Yes or N	10g. Citizen of		ntry?	ity Limits 2 X No
Maryland 21215-0036	72 hours after of natural, or iter airal Extrairer	by	1 Never Married 2 Mai 3 Widowed 4 Divorces	Armed Force	es? □No Δτπυ	16a. Dece	f Yes, specify Cub 1 Yes 2 No dent's Usual Occup kind of work done	Specify:	Puerto Rican, etc.)		W	hite	
12121	e filed within at Hygiene. other than "	Completed	Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle	College (1-4	or 5+)	life.	State Brok	er	s Name (First, Middle		Imploye	xd	
rylano	2 should be and Mental I se marked or aumatic eve	To Be	John Romaine 19a. Informant's Name/Relation			105 Mailin	Address (Chron	Mary	Thorsen			Codel	
Baltimore, Ma	permit. Pages 1 and 2 s Department of Health an Important: if item 27 is i any njury or other traur 2006s.		John Romaine (\$20a. Method of Disposition 1 \$\mathbb{X}\$ Burial 2 Cremation 4 Donation 5 Other (\$200)	Son) 3 □Removal from St	ate	6206 Place of Dispo	Satinwood : sition (Name of matory or other pla ant Cemeter	Drive	or Rural Route Numb Columbia, N Date 1-18-2010		21044 - City or To	own, State	.d.
Baltir	permit. P Departme Importan any njur		21. Signature of Funeral Service		, , ,	22 W	Name and Addre Nitzke Fune 1555 Twin K	ss of Facility	s. Inc.				ı K
	Physician /Medical		23a. Part1. Enter the disease of shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)	a	ised the deat	h. Do not ent	er the mode of dyll	ng, such as ca	ardiac or respiratory	ia, Maryla	1111 210	Approxima Interval Be Onset and	tween
o,	icate be executed physicien and physicien and sthe burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or		Co Non quence of):	iany ian	the	O War Medi	Veel	305	416.	r .
68760,	ifficate be g physici as the bu	ledicai		d	rite.			GENTH TOWN					
P.O. Box	Attending Physician: The law requires that the death certific in death. In death. In this certificate has been signed by the attending p by the funeral director, page 2 should be detached for use as it.	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		h 2 Feta nt at time of c	ildeath 3□	Ectopic pregnanc Other (specify)	ý			ate of delivi		Year
	w requires that been signed to should be deta	by	Part II. Other significant conditions of the production of the pro	15 FLACTU	ues -	- Mr	, , ,			tobacco use cor Yes 2□No	ntribute to t	1	death? Unknown
al Reco	iician: The law ri certificate has be rector, page 2 sh	Completed	ACTIONSA	-THE K	ESMES	UTTA			24a. Wa auto perf 1 🗌 Yes		were auto prior to co death? 1 \(\sum \text{Yes}	opsy findings empletion of a 2 No	available cause of
of Vita	Physician r this certifi rral director	To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death	Hospital:		ER/Outpatier		ner: 4 Nurs	ing Home 5 Res	-		fy)	
Division of Vital Records,	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Certification:	1 Natural 5 Pendi 2 Accident invest 3 Suicide 6 Could 4 Homicide detern	ng (Month, 12/7) not be consed 28e. Place of	Injury - At h	UNKMO ome, farm, str	www 1 = eet, factory, office	Yes 2000	28f. Location City or To	(Street and Number, State)	750 L1		nber,
	To the Hospital or A within 24 hours after To the Funeral Direction Completely filled in by	edical C	29a. Certifier 12 Certifyi (Check only one) 2 Medical	ng Physician: To the b Examiner: On the bas and manne	est of my kno	wledge, death	occurred at the tr	me, date and	place, and due to the	cause(s) and m	nanner as s	stated. o the cause(s)
	To th within To th comp	Me	29b. Signature and title of artific	Hours	I m	2	29c. Licens	00	20390	29d. Date sign	14/2	010	
			30. Name and address of person CI JVAVCUS S 31. Date filed (Month, Day, Year	who completed cause	of death (Iter	n 23a) (Type, 1 3900	Print) Locid 14	NEW K	scip; Bo	inmal	c m.	0 212	18
	Sta Registr		31. Date filed (Month, Day, Year	32. Reg	pistrar's Signa	auto o			·				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene = State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 11:32 January Helga Anna Ronnett Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Gilchrist Center for Hospice Care Towson 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🂢 F Feb. 5. Months Days Hours Min. Director <u>481-34-4660</u> 84 Germany Usual Residence of Decedent or 28a-f show 10a. State item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10c, City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🔀 No Baltimore Lutherville 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral USA 21093 1211 Broadway Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc 1 Never Married 2 Married <u>۾</u> Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: Specify: Completed 3 X Widowed 4 Divorced white 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Journalist Newspaper Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental H မ Olga Holz Gunther Wangerin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 sl of Health a item 27 is 1211 Broadway Road; Lutherville, MD 21093 Gabriele V. Ronnett / daughter Baltimore, 20a. Method of Disposition
1 ☐ Burial 2 🖸 Cremation 3 ☐ Removal from State permit. Page 1 a Department of H Important: If ite 20b. Place of Disposition (Name of cemetery, crematory or other place, any injury or 4 Donation 5 Other (Specify) Hilltop Service Corp | 1/15/10 Towson, MD 21. Signature of Fune a Service I 22. Name and Address of Facility 1050 York Road MD 21204 Ruck Towson Funeral Home, Inc. Towson, 23a. Part 1. Enter the disease, or complications to t caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betweer shock, or heart failure. List only one cause Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) incre Medical Due to (as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated exercts. Examine that initiated events resulting in death) Last Due to (or as a consequence of) anding physician use as the burial Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) ____ in the past 12 months?
1 \(\subseteq \text{ Yes} \quad 2 \subseteq \text{ No} \) Pregnant at time of death Month Day Year been signed by the should be detached 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 2 No 3 ☐ Probably 4 ☐ Unknown Completed 1 🗌 Yes 24a. Was an 24b. Were autopsy findings available prior to completion of cause of To the Hospital or Attending Physician: The law r within 24 hours after death.

To the Funeral Director: After this certificate has b autopsy performed Yes 2 death? 1 🗌 Yes **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 1 Natural 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 Tes 2 🗌 No Investigation 6 Could not be Accident 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State

Registrar

6701 N. Charles ST TOW -ON MO MO 31. Date filed (Mont

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

re and title of certifie

58303

29d. Date signed (Month, Day, Year)

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2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deat Physician/ Jamüarv 13 20110 1:25 В. Roberts ВM Evelyn Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore Towson Pickersqill Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Days Ma Wont 2 9 3, 1926 1 □ M 2 🕱 F Hours 83 May y and Director 212-22-9626 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10a State 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Towson 1 Yes 2 X No Md. 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21204 USA 615 Chestnut Ave Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc þ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify: Specify: White Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Education Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Wilton Benson Evelyn Hershner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 412 Briddlewreath Way Mount Airy, Md. 21771 Mr. Drew Roberts/ Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Dulaney Valley Mem. 1-16-10 Timonium, Md. ^{22. Nam}Rand Addres of Facility Funeral Home, 1050 York Rd. Towson, Md. 21. Signature of Funeral Serv e Lio 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease Pnysician hronic disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, If any, leaching to immedia cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of signed by the attending physician and be detached for use as the burial-transit The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death

9 Unknown 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Day Year Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 🗹 No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed After this certificate 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 No 1 🗌 Yes ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 □ Yes Certificate: 28d. Describe how injury occurred 5 Pending iniury 1 Natural 2 No 2 Accident
3 Suicide
4 Homicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier

Registrar
DHMH 17 Rev 7/2009

State

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30. Name and address of person who completed

31. Date filed (Mo

M. Charle St. Polts. Md

cause of death (Item 23a) (Type, Print)

Registrar's Signa

Registrar DHMH 17 Rev 1/2001

State

ATUMDE

31. Date file

ATME

BATTIMORE MI) 21215

Mi)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 00806 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ J Month 0530 AM **FLORENCE** RUDNER Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death UNION MEMORIAL HOSPITAL BALTIMORE N/A 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral 1 □ M 2 🗶 F Days Hours 9/77 1914 Director 95 Yrs. MD 216-18-5428 Usual Residence of Decedent 10a, State Page 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director or 28a-f 1 X Yes 2 No BALTIMORE MD N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 700 WEST 40TH STREET, #260 21211 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. Š 1 Never Married 2 Married "natural", or Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Completed 3 X Widowed 4 Divorced Specify: WHITE the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Seconday (0-12) College (1-4 or 5+) NURSE MEDICAL Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ပ LEBOWITZ LOUIS SARAH BENJAMIN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. LEWIS RUDNER / SON 2408 SHELLEYDALE DRIVE, BALTIMORE, MD 21209 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place, ANSHE NEISEN CONG. 1/17/2010 4 Donation 5 Other (Specify) ROSEDALE, MD 21. Signature of Funeral Service Lie 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death Physician/ Gashoinstellin disease or condition Medical resulting in death) r as a consequence of) **Examiner** Sequentially list conditions, Examine Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or iinjury that initiated events attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 Live Birth 2 L retail death
4 Pregnant at time of death
9 Unknown 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ signed by the atte in the past 12 months?
1 Yes 2 No Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Advanud 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an -oidisn autopsy 2 X No 1 Yes 2 No Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No Other: ၀ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) after death.

Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending 1 Tes 2 No Investigation Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature a

Registrar
DHMH 17 Rev 7/2009

State

East University

32. Registrar's Signature

212

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

201.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 00807 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Bhavna Singh 10:10 p M 2010 Medical Januarv 4a. Facility Name (if not institution, give street and number) Examiner 4b, City, Town, or Location of Death 4c. County of Death National Institutes of Health Bethesda Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Funeral Min. 1 □ M 2 🖼 F Hours 999-99-9999 42 Director India Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits Direct St. Thomas Barbados, Barbados 1 ☐ Yes 2XXNo St. Thomas 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? NA Funeral 3 Cane Garden Cresent India 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married ģ Maryland 21215-0036 within 72 hours after 1 Yes 2 No Specify: Asian Indian "natural". 3 Widowed 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Medical Doctor Medical Medical 2 should be filed with h and Mental Hygier 7 is marked other t 5+ other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Raghunath Singh Uma Devi 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Alok Kumar / Husband 3 Cane Garden Cresent, St. Thomas, Barbados permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other: Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Chesapeake Crematory 1/6/2010 Beltsville, MD 21. Signature of Fune al \$ 700 e Licensee Name and Address of Facility

PP Funeral and Cremation Services Ŕapp Gist Ave., 20910 Silver Spring. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph sician/ Epidural Hematoma disease or condition resulting in death) days Medical Due to (or as a consequence of): Examiner 3.5 weeks Brain mass Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to for as a consequence of Hodakin 's Lymphoma was and -tran that initiated events Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical #7500+1 FC Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Dav Year Pregnant at time of death Yes 2 No g 🗌 Unknown Unknown ed by t detach signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 certificate has autopsy performed or Attending Physician; The 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ပ္ 1 Mnpatient 2 ☐ ER/Outpatient 3 ☐ DOA this within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral or 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical Ecertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) D0069443/MD MD 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Janice Leung 10 Center Drive, Bethesda, Maryland 20892 31. Date filed (Month gistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		•	For State Registrar		State of Ma	aryland /	-	irtment of F tificate of	leaith and N <i>Death</i>		leg. No.	00808
	Physici	an	1. Decedent's Name	(First, Middle, Las	t)			-		2. Date of Dea Month	Day Ye	3. Time of Death
	/Medic	al	Virgi		Payne	Sc	hwar		r Location of Death	January	7 16, 201	
5	Examin	er		l lwood Dr	street and number)			Rockvi			Montgo	
	Funeral Director		5. Social Security No. 526-01-1	umber 6. Se		e (In yrs. last 93	birthday) Yrs.	If Under 1 Year Months Days		8. Date of Birth Month Day		Birthplace (State or Foreign Country) 111101S
	pug ≱ _		Usual Residence of 10a. State	Decedent 10b. County		10c. City, To	own or Lo	cation		-		10d. Inside City Limits
	Maryla -f eho	tor	MD	Montgome	cy	Rocky						1 ☐ Yes 2 🕅 No
	h the or 28a e notifi	irec	10e. Street and Nur	nber		1		10f. Zip Code			10g. Citizen of Wha	at Country?
	ath wil	ralD	6017 Nei	llwood Dr				20852			United S	
920	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. If maint and Mental Hygiene. Item 27 is marked other than "natural, or Items 23a or 28a-f show other traumatic evant, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 ☐ Never Marri 3 🏋 Widowed	ed 2 Married 4 Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:			Vas Decedent of H Yes, specify Cuba □ Yes 2 <u>K</u> No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No- Pican, etc.)	Specify:	American Indian, White, etc. White
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Man	2 sho			ame/Relationship (7							r, City or Town, Sta	
	1 and Health Iam 27 othar tr		Susan Sa 20a. Method of Disp		(daught	20b. Place	of Dispo	sition (Name of		Date	e, Maryla 20c. Location - Cit	
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j		1- For State Registrar		_	rtificate o					Reg. No.	20	11	0 00	RN
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		4 Donation 5 Other S 21. Signature of Funeral Service	Liconoco		_	Name and Addre								n . P
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Division of Vital Records, P.O. Box 68760, To the flospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans	-1	27. Manner of Death	28a Date	of Injury n, Day,Year)	28b. Time of	Injury 28c. Inj	ury at Wo	rk? 28	d. Describ	e how inj	ury occurre	d		_
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		30. Name and address of person	•											
		Pamela E. Southall, N		Medical Exa		11 Penn Stre	et, Baltii	more, MD	21201					
St	ate	31 JAGUET (AGILDAY (Cear)	72 - 32. R	egis ar's Signatu	ire									

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician 6:41 am^M 2010 Schreiber January 16, Catherine /Medical Pearl 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore 50 Wiltshire Road Essex If Under 24 Hrs. 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex **Funeral** Months 1 □ M 2 😾 F Director 3/24/1926 Maryland 83 220-18-5880 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 3a or 28a-f show t be notified at 10b. County 1 ☐ Yes 2 ☐ No Director Maryland Baltimore Essex 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 23a or permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a any Injury or other traumatic event, the Medical Examiner must. 21221 S. A. 14. Race - American Indian, Funeral 50 Wiltshire Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 □ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 💥 No Specify: Specify: <u>ک</u> White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Own_Home <u>Homemaker</u> 18. Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) Be ပ <u>Margaret</u> Riemer William Starr 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) John George Schreiber, Jr. (Husband) 50 Wiltshire Road Essex, Maryland 21221 20a Method of Disposition (Name of Date 20c. Location - City or Town, Sta Baltimore, 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/18/2010 Baltimore, Maryland Bayview Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bruzdzinski Funeral Home PA 1407 Old Eastern Avenue Essex, Maryland 21221 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) HYPONOVENIC tou 12 **Physician** /Medical Due to r as a consequence of): Examiner 0 ume if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed nore Due to (or as a consequence of) attending physician for use as the buria Cancen Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 💆 No 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 Probably 4 ☐ Unknown 1 Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No autopsy performed? 1☐ Yes 2 XNo Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) Hospital: 1 ☐ Yes 2X No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1X Natural 1 Yes 2 No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined

Records, P.O. Box 68760 Division or Vital or Attending Physician: Hospital the

within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral of

State Registrar

Medical

4 | Homicide

29b. Signature and title of certifier

29a, Certifier

30. Name and address of per-

29c. License number

I Xcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

who completed cause of death (Item 23a) (Type, Print)

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nando

32. Registrar's Signature 31. Date filed (Month, Day, Year) JAN 1 9 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ January 2010 9:00 P M Elizabeth Shirey Marlane Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Joseph Richey House Baltimore If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🖫 F Months Days Hours 05/20/1947 214-50-4342 Maryland Director Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b County 10c. City. Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits Director 1 Yes 2 No Maryland Baltimore Middle River 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21220 30 Stabilizer Drive U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Completed 3 Widowed 4 Divorced White Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) marked other than College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Owner/ Operator Accounting Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Myrtle Eldora Garman William Frederick Dehne and N 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 shent of Health a tant: If item 27 is 10002 Kenwood Road, Cincinnati, Ohio 45242 John Wayne Hutson (Son) 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o 1 Durial 2 Dremation 3 Removal from State 4 Donation 5 Other (Specify) Bayview Crematory 01/19/2010 Baltimore, Maryland 21. Signature of Funeral Septice Licensee ^{22. Name and Address of Facility}
Bruzdziński Funeral Home, P.A.
1407 old Eastern Avenue, Essex, Maryland 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease r condition resulting in death) limple node out liver metastase Physician/ (mocer with Medical Due (or as a consequence of) Examiner Sequentially list conditions, Examiner Directo (or se a consecuence of) if any, loading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1
Yes 2 □ No 3 □ Probably 4 □ Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 🗌 Yes 25. Was case referred to medical examiner? the Hospital or Attending Physician: Division of Vital Be 26. Place of Death (Check only one) TERNIER 1 Yes 2 No Other: ြို 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Hospical After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred ☑ Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29d. Date signed (Month, Day, Year) D041476 01.18.2010 M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (565 N CHARLES ST, SAME 416, BALTIMORE, MD RAYMOND W. WILSON M.D.

DHMH 17 Rev 7/2009

State Regist<u>rar</u> 31. Date filed (Month, Day, Year)

MAPLENE

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 19 Month **Physician** 1 2010 6:45 Raymond Stare /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Baltimore N. Marlyn Ave. Essex Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday, **Funeral** Days Hours Months 1**X**M 2□ F Director 172-24-9324 84 9/29/1925 Usual Residence of Decedent 10c. City, Town or Location with the Maryland 10d. Inside City Limits 10a. State 10h County 28a-f show the Medical Examiner must be notified at 1 X Yes 2 □ No Director MD Baltimore Essex 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number ō 839 21221 U.S.A. or items 23a N. Marlyn Ave. Funeral death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Yes 2 No Navy If Yes, Give Year or Dates: 6 Years 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔼 No Specify: White þ 3 ☐ Widowed 4 ☑ Divorced 'natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 6 Crane Steel Department of Health and Mental Hygie Important: If Item 27 is marked other I any injury or other traumatic event, the once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Stare Dimeler Charles ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Essex, MD 21221 Patrick Stare / Son 839 N. Marlyn Ave. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 1/20/2010 4 □ Donation 5 □ Other (Specify) Woodbine, MD Final Journey Crematory 21. Signature of Funeral Service Lice se Norota Marshall 22. Name and Address of Facility Maryland Cremation Services Mousin P.O. Box 1413 Baltimore, MD 21203 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) netastatio **Physician** 4 month /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months? Day 4□Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 es 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred I Director: After to in by the funeral 28c. Injury at Work? Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

To the Funeral Dir

State Registrar

Medical

31. Date Ned (Month, Day, Year)

MD

29b. Signature and title of certifier

29a. Certific

30. Name and address of person who completed cause of death (Item 23a) (Type, Pript)

Nin (M) 2014 Philadelphia Road # 208 32. Regist

29c. License number

29d. Date signed (Month, Day, Year)

January

19th 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year Physician/ Dawson Stump Jr. a^{M} 2010 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Baltimore 4b. City, Town, or Location of Death **Examiner** Gilchrist Hospice Towson 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Days 1 🕅 M 2 🗆 F 52 Months Hours Min. Country) 218-78-2895 Director 10 1957 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director is marked other than "natural", or items 23a or 28a-f si aumatic event, the Medical Examiner must be notified MD Baltimore Owings Mills 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4 Cliffholme 21117 USA Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Race - American Indian Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. 1 Never Married 2 Married þ 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🙀 No Specify: White 3 - Widowed 4 - Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Business Owner Automotive 12 Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Sarah Price Dawson Stump 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once, 4 Cliffholme Road, Owings Mills, MD 21117 Dawson Stump / Father Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crem. 01/18/2010 Woodbine, MD 21. Signature of Funeral Service Licensee Dorota Marshall 22. Name and Address of Facility Maryland Cremation Services PO Box 1413, Baltimore, MD Lansham 203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ do cal disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cauce. Enter Underlying Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director, After this certificate has been sinned by the attendance account. Cause (Disease or linjury that initiated events attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death
Unknown 5 Other (specify) signed by the a Id be detached f Yes 2 No g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 Yes Yes To the Funeral Director, After this certifics completed filled in by the funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) 1 Yes 2 No Other lasyn'co မ 4 Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 27 Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 🗆 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of pay knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) George

Registrar
DHMH 17 Rev 7/2009

State

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Day Yea Month **Physician** Silseth 13 nobert January 2010 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A Baltimore City The Johns Hopkins Hospital Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number **Funeral** 212-42-4998 Maryland 8, 1943 Jul. Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1 Yes X No Baltimore Director MD Baltimore 10g. Citizen of What Country? United States 10f. Zip-Code 10e. Street and Number 21227 1156 Elm Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 1 Yes 2 No 1964— If Yes, Give Black, White, etc. 1 Never Married 2 Married Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. "natural", or 1 ☐ Yes 2 💢 No White ò Specify: 3 Widowed 4 Divorced 1974 Year or Dates: Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Baltimore County Elementary/Secondary (0-12) College (1-4 or 5+) Police Department Polce Officer is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Cecilia Mary Lee Nymore O. Silseth မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, Cify or Town, State, Zip Code) 1156 Elm Road, Baltimore, MD 21227 permit. Pages 1 and 2 s Department of Health a Important: If item 27 is any injury or other trau once. Helen L. Silseth - Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 14 Burial 2 ☐ Cremation 3 ☐ Removal from State Loudon Park Cemetery 1-18-2010 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral 22. Name and Address of Facility Ambrose Funeral Home, Inc. arvice Licensee 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part 1. Enter the disease, or complications that caused a shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final **Physician** Preumonia disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Luisease Examine Due to (or as a consequence of) (Disease or injury that initiated events attending physician and for use as the burial-trar resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 🗌 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 K Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1X Yes 2 XNo 2 🗌 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 🗀 Yes မ this 28b. Time of Manyler of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: I Director: After the din by the funeral 1 Nature. 2 Accident Pending investigation Injury 1 🗌 Yes 2 🗌 No death. Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide Cify or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

or Attending Physician: The law requires that the death certificate be executed Box 68760, P.O. Division of Vital Records, filled in by Hospital e Funeral C

death with the Maryland

Baltimore, Maryland 21215-0036

Medical To the within 2 lox

(check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier ndricks, D.O. RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

January 13. 9010

600 North Wolfe St, Baltimore, MD, 21287

Hendricks Latonya 0.0 M 31. Date filed (Month) Day, Year)

State Registrar

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Physicia /Medica Examine

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It a Nortical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

	For State Registrar	Ceri	ificate of Death	, 0	. No.	00015
	Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year	3 Tirtle di Death
n Il	Mollie	Smith			17, 2010	8:15 A M
r	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Dea	th	4c. County of Death Baltin	
	Genesis Eldercare - Heritage 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Dundalk If Under 1 Year If Under 24 Hrs	8. Date of Birth	9. Birth	place (State or Foreign
	216-46-7924 1 M 2 M F	93 Yrs.	Months Days Hours Mir	(Month Day)	,1916 Mary	intry)
	Usual Residence of Decedent	0- 0% Town as I as	- No.			10d. Inside City Limits
_		Oc. City, Town or Loc:	alion Idalk			1 ☐ Yes 2 ☐ KNo
ect	Maryland Baltimore 10e. Street and Number	Dui	10f. Zip Code	100	Citizen of What Cou	intry?
Funeral Directo	2513 Liberty Parkway		21222		USA	,
ner	11. Marital Status 12. Was Decedent Eve Armed Forces?	er in U.S. 13. W	las Decedent of Hispanic Origin? (Yes, specify Cuban, Mexican, Pue	Specify Yes or No-	14. Race - Amer Black, White	
à	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates:		□Yes 2 No Specify:	,,		hite
Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Decede	ent's Usual Occupation Ind of work done during most of wo O NOT use retired)	rking 16	b. Kind of Business/li	ndustry
dmc	Elementary/Secondary (0-12) College (1-4or 5+)		Beautician		Hair Sal	_on
င်	8 years 17. Father's Name (First, Middle, Last)			me (First, Middle, Ma		
0 13	Michael Ruth		Berth	a Kelch		
	19a. Informant's Name/Relationship (Type. Print)	M	Address (Street and Number or F			
	Betty Ann Ruth Spencer Daught		Liberty Parkway		Maryland 2	
	20a. Method of Disposition 1 ☐ Gurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Dispos cemetery, crem. Oak Lawn		iarv	rundalk, Ma	
, in	21. Signature of Funeral Service Licensee	LU/ 171	Name ad Address of Facility 10 Sollers Poin	t Road, Du	ndalk,Md.	21222
	23a. Part 1. Enter the disease, or complications that caused th shock, or heart failure. List only one cause on each line.	e deat l Do not ente	r the mode of dying, such as cardi	ac or respiratory arres	it,	Approximate Interval Between
	Immediate Cause (Final disease or condition a CORON	LARY A	RTERY DISE	ASE		Onset and Death
	resulting in death) Due to (or as a c		0152.50			
ē	if any leading to immediate Due to (or as a c	ETES	MELLITY:	>		1
Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c. HYP	ERTEN	5104			
Exa	resulting in death) Last Due to (or as a c	onsequence of):		-		
edical	d. DEM	ENTIA				
5	IF FEMALE: 23c. If yes, outcome of	pregnancy			Ond Date of dell	
Physician/I	in the past 12 menths?	☐ Fetal death 3☐	Ectopic pregnancy Other (specify)		23d. Date of deli Month	Day Year
Jysi	1 □Yes 2 ☑No 4 □ Pregnant at til 9 □ Unknown 9 □ Unknown					
	Part II. Other significant conditions contributing to death but	not resulting in the un	derlying cause given in Part I.	23e. Did toba	icco use contribute to	_
ed				1 ☐ Yes	2 No 3 Pr	obably 4 Mknown
Completed by				24a. Was an autopsy	prior to c	topsy findings available completion of eause of
5				perform 1 🗆 Yes 2	ed? death? 1 ☐ Yes	2 No
Be			26. Place of D	eath (Check only one,		
	25. Was case referred to medical examiner?	2 T F2/2 4 - 4 - 4	Other:		о Понь «	<i>"</i>
	examiner? 1 Yes 2 No Hospital: 1 Inpatient 27 Manner Death 28a Date of Injury	28b. Time of	3 L DOA 4 Nursing		ice 6 ☐ Other (Special Injury occurred	cify)
	examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient	28b. Time of	Other: 4 Nursing 28c. Injury at Work? M 1 Yes 2 No	Home 5 ☐ Resider		cify)
	examiner? 1 Yes 2 No Hospital: 1 Inpatient 27. Manner of Death Altural 5 Pending 2 Accident investigation	28b. Time of Injury	28c. Injury at Work? M 1 □ Yes 2 □ No	Home 5 ☐ Resider 28d. Describe how	injury occurred	
	examiner? 1 Yes 2 No 27. Manner of Death Natural 5 Pending Investigation 3 Suicide 6 Could not be determined 28e. Place of Injury (Month, Day, 1) 28e. Place of Injury building, etc.	28b. Time of Injury - At home, farm, stre	28c. Injury at Work? M 1 Yes 2 No et, factory, office	Home 5 Resider 28d. Describe hov 28f. Location (Street, City or Town,	r injury occurred set and Number or Ru State)	ral Route Number,
	examiner? 1 Yes 2 No Hospital: 1 Inpatient 27. Manne of Death Natural 5 Pending investigation 2 Accident investigation 3 Suicide 6 Could not be charming and suicide 28e. Place of Injury	28b. Time of Injury - At home, farm, stre (Specify) my knowledge, death xamination and/or inv	28c. Injury at Work? M 1 Yes 2 No et, factory, office	Home 5 Resider 28d. Describe how 28f. Location (Strr. City or Town,	r injury occurred set and Number or Ru State) use(s) and manner as	aral Route Number,
	examiner? 1 Yes 2 No Hospital: 1 Inpatient 27. Manner of Death Natural 5 Pending investigation 3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury building, etc. 29a. Certifier (Check only one) 1 Certifying Physician: To the best of 2 Medical Examiner: On the basis of e and manner state	28b. Time of Injury - At home, farm, stre (Specify) my knowledge, death xamination and/or invide.	28c. Injury at Work? M 1 Yes 2 No et, factory, office occurred at the time, date and plaestigation, in my opinion, death occurred at the time of the second occurred at the time.	Home 5 Resider 28d. Describe hov 28f. Location (Strr. City or Town, ce, and due to the cacurred at the time, da	rinjury occurred set and Number or Ru State) use(s) and manner as te and place, and due	s stated. to the cause(s)
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Medical Certification: To I	examiner? 1 Yes 2 No 27. Manne of Death 1 Natural 5 Pending investigation 3 Suicide 4 Homicide 5 Could not be determined 29a. Certifier (Check only one) 1 Certifying Physician: To the best of eand manner state.	28b. Time of Injury - At home, farm, stre (Specify) my knowledge, death xamination and/or invide.	28c. Injury at Work? M 1 Yes 2 No et, factory, office occurred at the time, date and plaestigation, in my opinion, death occurred at the time of the second occurred at the time.	Home 5 Resider 28d. Describe hov 28f. Location (Strr. City or Town, ce, and due to the cacurred at the time, da	rinjury occurred set and Number or Ru State) use(s) and manner as te and place, and due	s stated. to the cause(s)

Stat Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Day Month **Physician** francis J. ~ /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Howard County General Hospital Columbia If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Social Security Number 8. Date of Birth (Month, Day, Year, Funeral Months Days Hours Min. 1 M 2 □ F 011-24-3157 78 Director July 10,1931 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10h County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at Directo Maryland Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6066 Camelback Lane 21045 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No If Yes, Give Year or Dates: Specify þ Specify: Navv 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Electrical Engineer NSA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Department of Health and Menta Important: If item 27 Is marked any Injury or other traumatic ev George Sweeney Mary Bagnall ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Wife) Columbia, Maryland 21045 Ann Sweeney 6066 Camelback Lane 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 🕱 Burial 2 ☐ Cremation 3 ☐ Removal from State 1-18-2010 Columbia Memorial Park 4 Donation 5 Other (Specify) Clarksville, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Witzke Funeral Homes, Inc 5555 Twin Knolls Road Columbia, Maryland 21045 23. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) i signed by the a d be detached for TYes 2 TNo 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has e 2 autopsy 01

To the Hospital or Attending Physician: The law requires that the death certificate be executed his certificate I funeral neral Director: Α filled in by the fi within 24 hours a

loren.	ra Ka	·63	Discore					1	performed? ☐Yes 2-2N		eath? ⊒Yes	2 No	
25. Was case refer	red to medical						26. Place of De	eath (Che	eck only one)				
examiner? 1∐Yes 2 ∑	No	Hospital:	1 ☐ Inpatient 2 🗷	ER/Outpatient	3 🗆 [D O A	Other: 4 \(\sum \) Nursing \(\)	Home	5 Residence	6 ☐ Other	(Speci	ify)	
27. Manner of Deat 1. X Natural 2	h 5 □ Pending investigation		Date of Injury (Month, Day, Year)	28b. Time of Injury	М	28c.	Injury at Work? 1 □ Yes 2 □ No	28d. [Describe how inju	ury occurred	1		
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e.	Place of Injury - At he building, etc. (Specif	ome, farm, stree	t, facto	ory, of	fice	28f. L	ocation (Street a lity or Town, Sta	ind Number te)	or Run	al Route Num	ıber,
29a. Certifier (Check only one)		niner: On					the time, date and plac my opinion, death occ						;)

	OHE)				
29b.	Signature	and	title of	certifier	
	1		1/2	1-16	

25. Was cas

27. Manner

Be

Certification: To

Medical

State Registrar 29c. License number D00544Q4

2010

29d. Date signed (Month, Day, Year)

Year

2010

Howard

6:02P

Birthplace (State or Foreign Country)

Massachusetts

White

10d. Inside City Limits

Approximate Interval Between Onset and Death

yews

Year

Day

1 ☐Yes 2 No

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Columbia, Maryland 21044

Donald A. Berlin, M.D. 5755 Cedar Lane

31. Date filed (Month, Day, Year,

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 3A~ Physician/ Vear Robert R. Scratcher 1.45 A M 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ashinstonmedical Cente Burnie Arunde Sex 1 M 2 □ F If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min. Hours July 12, 1926 Illinois 338-18-6313 83 Director Usual Residence of Decedent or 28a-f show notified at 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🔽 No Anne Arundel MD Odenton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō "natural", or items 23a or edical Examiner must be Funeral U.S.A. 1122 Court Revere 21113 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11 Marital Status Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. ģ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 Ϊ No Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates er than "natur, the Medical E 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other the any injury or other traumatic event, the angles. 12 Food Service Specialist U.S. Army Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Raymond Edward Scratcher Loretta Granet 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Louise C. Scratcher/Wife 1122 Court Revere, Odenton, Maryland 21113 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Durial 2 X Cremation 3 Removal from State Arundel Crematory | 01-16-2010 4/ Donation 5 ☐ Other (Specify) Odenton, Maryland 21. S and ure of Funeral Service Licens 22. Name and Address of Facility Donaldson Funeral Home & Crematory, 1411 Annapolis Road, Odenton, Maryl 23a. Part 1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ eres wasevlar Accielent disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner colon (Ance years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to for as a row section over the ng physician and as the burial-transit that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Por Month Pregnant at time of death Day Year detached the Unknown g 🗌 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by page 2 should be Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performe 1 ☐ Yes 2 ☐ No certificate Yes 2 No within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, I 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Other: 1 Monpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 2 Accide 5 Pending 1 Yes 2 🗌 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \square Homicide Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title certifie 29d. Date signed (Month, Day, Year) 0 Elemel, JAN 14 00059190 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4 GURLE 301 BAFFOF-BONNE HOSPITAL 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** 11 - 23 AM Chinton 2010 15 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Righanal Year If Under 24 Hrs. 8. Date of Birth (Month, Day, May 25, 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Sex 1 M 2 □ F Days Min. 1934 Maryland 75 215-30-0931 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show ns 23a or 28a-f shormust be notified at 1 ☐ Yes X No Director Laurel Maryland | Prince George's 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with 20708 U.S.A. 8610 Kiama Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? ₩₩8es 2□No 1956 If Yes, Give Year or Dates: -1959 th and Mental Hygiene.
It is marked other than "natural", or items traumatic event, I'm Modical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married XX Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: 2 White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Engineering Tech. Writter Westinghouse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elizabeth Ernde Elmer Clinton Shettle 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Health a 8610 Kiama Road Laurel, Maryland Bernadine A. Shettle spouse item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Ę Department of Important; If it any Injury or conce. XXBurial 2 ☐ Cremation 3 ☐ Removal from State Baldwin Memorial Cem. 01/23/2009 Millersville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Donald Son Funeral Home, P.A. ✓ M00770 Laurel, Maryland 20707 313 Talbott Avenue Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or comshock, or heart failure. List only plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, the cause on each line. Immediate Cause (Final **Physician** Due to (or as a consequence if): disease or condition resulting in death) /Medical Examiner hallakon Sequentially list conditions, if any leading trimmediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Physician/Medical Examiner To the Hospital or Attending Physician; The law requires that the death certificate be executed ent tusion certificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial-tran Due to (of at a consequence of): Division of Vital Records, P.O. Box 68760, Mahid IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Year Month g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 | Yes 2 | No 3 | Probably 4 | Unknown Aprison 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 🗹 No 1 ☐ Yes 1 ☐ Yes director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No After this of funeral direction 1 ■Inpatient 2 □ ER/Outpatient 3 □ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation death. 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director: A 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (PP) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d Date signed (Month, Day, Year) 29b. Signature and title of certifier Karunwi

State Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

r dr

31. Date filed (Month, Day, Year)

Harunni

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Estelle Schisler Marie 2010 9:30 January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Co. Riverview Nursing Home Essex 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 212-09-0900 1 □ M 2 🖵 F Months Days Hours Min. Director March Marvland Usual Residence of Decedent or 28a-f shov notified at 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits with the Maryland Director 1 ☐ Yes 2X No Anne Arundel Linthicum MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? օ ed other than "natural", or items 23a of event, the Medical Examiner must be Funeral 6437 Orchard Road 21090 United States Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Bace - American Indian. Yes, specify Cuban, Mexican, Puerto Rican. etc. Armed Forces?
1 ☐ Yes 2 ☐ No Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 X No Specify: 3X Widowed 4 ☐ Divorced Year or Dates White Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Laborer Food Distributor 5 Years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Sophie Nickels Department of Health and Men Important: If item 27 is marke any injury or other traumatic John Vitak 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u> Rosemarie Stroheker(Daughter)</u> 6437 Orchard Road Linthicum, MD 21090 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place 1 🗓 Burial 2 🗆 Cremation 3 🗖 Removal from State 4 Donation 5 Other (Specify) 1/13/2010 Park Baltimore, Maryland Mem. Signature of the ral Service Le 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Dundalk, ATTO 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) e or earta Q00 06 Medical Tue to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): signed by the attending physician and d be detached for use as the burial-transit Cause (Disease or imjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) 4 ☐ Pregnant : 9 ☐ Unknown 9 Unknown Hospital or Attending Physician: The law requires that the 24 hours after death. Funeral Director: After this certificate has been signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 4 perterior Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown been si should l Hypertoideoria 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed Yes 2 estechoronis 2 No 1 Yes 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 2 No မ 1 \square Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury Natural 5 Pending Accident Investigation filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. сотріете 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the Within 2 To the F only one)

State Registrar 31. Date filed (Month

1310 Ritchie H

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Reg

roantz 10

29c. License number

D19667

29d. Date signed (Month, Day, Year)

4508 Bleu Briver Hayland 21061

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 7:15 PM Leo Le Roy Sumlin January 2010 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Harford Bel Air Upper Chesapeake Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Dec. 21,1921 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Hours Months Days 1**∑**MM 2□ F 88 Maryland 215-14-6917 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location Harford Bel Air 1 ☐ Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 700 Flintlock Drive 21015 12. Was Decedent Ever in U.S. Armed Forces? 1♥17/es 2 □ No If 76's, Give Ye ar or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Never Married 2 Married 1 ☐Yes 2X No Specify: Specify: 3 Widowed 4 Divorced White WWII 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry United States Flementary/Secondary (0-12) College (1-4or 5+) rnment name) wn, State, Zip Code) yland 21015 on - City or Town, State

29d. Date signed (Month, Day, Year)

700 Flintlock

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinar must be neithed at

Examine

Completed by Physician/Medical

Be

Certification: To

Medical

State Registrar 31. Date filed (Month, Day,

29a, Certifier

and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print

MD

32. Registra s Signature

Physician

/Medical

Examiner

10a. State

MD

Director

Funeral

δ

Completed

Be ပ

Funeral

Director

nours after death with the Maryland

Physician /Medical **Examiner**

signed by the attending physician and I be detached for use as the burial-tran

within 24 hours after death.

To the Funeral Director: After this certificate has been si completely filled in by the funeral director, page 2 should I the Hospital or Attending Physician:

12 Years		Industrial Sp	ecialist	Go	overnment	
17. Father's Name (First, Middle, Last)			18. Mother's Name (First, Middle, Maiden Surname)			
George Sumlin			Myrtle:	McConville	2	
19a. Informant's Name/Relationship (Ty) Mrs. Dolores E. St		19b. Mailing Address (Street 700 Flintloo				^{Code)} 21015
20a. Method of Disposition **XXX*Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	emoval from State Par	ace of Disposition (Name of metery, crematory or other place when the contract of the contract	ze) 1/12/		ocation - City or To	
21. Signatury of Juneral Service License	Read	22. Name and Addre Duda-Ruck	Funeral 1	Home of Dundalk, Mar	ndalk, Ir yland 21	nc. 222
23a. Part 1. Enter the disease, or compli- shock, or heart failure. List only or	cations that caused the death. se cause on each line.	Do not enter the mode of dyin	ng, such as cardiac or	r respiratory arrest,		Approximate Interval Between Onset and Death
Immediate Cause T inal disease or condition resulting in death) a. Complications from bild tool Subaural Venutariae Secondary to all Due to (or as a consequence of):						
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequent)	THEOREM BY DESIGNATION OF THE PROPERTY OF	A SCENIFICATION A	1192	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1					23d. Date of delivery Month Day Year	
Part II. Other significant conditions con	stributing to death but not resul	ting in the underlying cause giv	en in Part I.	23e. Did tobacco	use contribute to th	e cause of death?
Coronary artery disease				1 ☐ Yes 2	1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown	
Peripheral vascu	lar disease	_		24a. Was an autopsy performed?	prior to cor death?	psy findings available npletion of cause of 2 No
25. Was case referred to medical examiner?	26. Place of Death (Check only one)					
1. Yes 2 □ No	Hospital: 12 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)					
27. Manner of Death 1 Natural 5 Pending investigation	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury at Work? 28c. Injury at Work? 28d. Describe how injury occurred 28d. De					bed
3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)			28f. Location Street Number or Rural Route Number, City or Town, State)		

DHMH 17 Rev 1/2001

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2010 Year Debbie Jane Shah АМ January 9:00 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Center for Hospice Care Towson Baltimore 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth 1 🗆 M 2 🗶 F Hours Min. 0ct. 4. 1969 Director 273**-**74**-**7845 40 Ohio Usual Residence of Decedent other than "natural", or items 23a or 28a-f show vent, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 722 E. Lake Avenue 21212 USA Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Completed by 1 Never Married 2 X Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: 3 - Widowed 4 - Divorced white Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) <u>Homemaker</u> <u>Own Home</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edwin Ruh1 Cho Song 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Paulesh K. Shah husband Lake Avenue: Baltimore. MD 21212 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1

Burial 2

Cremation 3

Removal from State 4 Donation 5 Other (Specify) Hilltop Service Corp 1/18/10 Towson. 21. Signature of 22. Name and Address of Facility 1050 York Road Ruck Towson Funeral Home, MD 21204 Inc. Towson, 23a. Part 1. Enter the disease, or complica shock, or heart failure. List only one ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betwee use on each line. Immediate Cause (Final Physician/ inset and Death disease or condition ears. Medical resulting in death) Due to (or as a consciuence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence on attending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown the Hospital or Attending Physician: The law requires that the death Month Day Year ed by the detached 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. cate has been signed page 2 should be det 23e. Did tobacco use contribute to the cause of death? ò Completed 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has autopsy funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 2 No Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at work?
1 Yes 2 No 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 Dending Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical Decertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

Division of Vital Records, To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this sompleted filled in by the P

2010

31. Date filed (Month, Day, State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

only one

29b. Signature and title of certifier



Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Fractioners to the cause of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Charles ST

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Physician/ 1:47 P Goldie K. Thomas 14, 2010 Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Gilchrist Hospice Center

5. Social Security Number 16. Sev <u>Baltimore</u> Towson If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Age (In yrs. last birthday) **Funeral** (Month, Day, Year) Months Days Hours Min. Country) 1 M 2 XF Yrs. Director Jan 28, 1915 323-18-1736 Usual Residence of Dec 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2- No Columbia Howard 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 21044 6336 Cedar Lane Apt. 378A Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married ð 1 Yes 2 No Specify Baltimore, Maryland 21215-0036 If Yes Give 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Clerical / State Govt Administrative Secretary 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) ပ Thomasia Krzeli John Katich 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) <u> 10735 Cleos Ct. Columbia, MD 21044</u> William Thomas 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition cemetery, crematory or other place) ☐ Burial 2 Cremation 3 ☐ Removal from State Jan 15, 2010 Sykesville, Maryland Donation 5 D Other (SpeQfy) All County Cremation Services thre of Juneral Service 22. Name and Address of Facility Slack Funeral Home, P.A.

3871 Old Columbia Pike Ellicott City, MD 21043

Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final disease or condition resulting in death) CordiongonaThy Physician/ Ischemic Medical Due to (or as a consequence of) Éxaminer Sequentially list conditions, if any, leading to minimize the cause. Enter Underlying Examiner Due to for as a consequence off: Cause (Disease or linjury To the Hospital or Attending Physician: The law requires that the death certificate be executed has been signed by the attending physician and e 2 should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No Dav Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by artonal distate 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed?

Yes 2. No after death.

Director: After this certificate ha 2 🗆 No 1 Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: 2 XNO 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) မ 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 27. Manner of Death Certificate: iniury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

D

State

MANUN

31. Date filed (Month, Day, Year)

JAN 19 2010

par

670i

M

32. Registrar's Signature

CHANCES

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 00823 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month LAT TYLER Year TON 41A 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death CATONSVILLE SUMMIT ARIC BALTIMONE If Under 1 Year If Under 24 Hrs. 5. Social Security Number . Sex 1 **X** M 2 □ F 7. Age (In yrs. last birthday) 8. Date of Birth Funeral 9. Birthplace (State or Foreign Country) 220-20-155 81 Months Days Hours Director Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at Director 10d. Inside City Limits 1 Yes 2 No timore 6 10g. Citizen of What Country 23a Funeral 72 hours after death Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. "natural", or 1 Never Married 2 Married Completed by 1 Yes 2 No Maryland 21215-0036 1 Tes 2 No Specify: Specify: Black 3 Divorced 4 Divorced Year or Dates. the Medical 16a. Decedent's Usual Occupation (Give kind of york done daying most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Se**4** nday (0-12) College (1-4 or 5+) het Be ler Baltimore, 20a. Method of Disposition Date 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery cremate 21. Signature of Funeral Service License 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Appr ximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Anier Onset and Death DISEATE CORONARY Hiysician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner DIJEAJE OBSTRUCTUE CHRONIC PULLINARY Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): OROPHARYNGEAL that the death certificate be executed CARCINONA sate has been signed by the attending physician and page 2 should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? 4 Pregnant at time of death Month Day Year 1 Yes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by HADERJENDIM Hospital or Attending Physician: The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown DUE TO ANOXIC 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate performed' 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: To the Hospital or Attending Physi within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir ည Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending work? 1 ☐ Yes 2 ☐ No 2 ☐ Accident 3 ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined edical 29a. Certifier Lecritifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b, Signature and title of certifier 29c, License number 29d. Date signed (Month, Day, Year) TENOING D6056948 2010 JAN

DHMH 17 Rev 7/2009

State Registrar SUTE 3H BATIM ME MO 21201

300 Armon

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 ANSINDA

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death lent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2010 21:05 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Samaritan HOSPITOI Baltimore If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) Funeral Director 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 72 hours after death with the Maryland 10d. Inside City Limits Director BaHiMore 1 🗶 Yes 2 🗌 No 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 1 L Yes 2 No If Yes, Give Year or Dates. Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event; the Mec life. DO NOT use retired) Be 17. Father's Name (First, Middle, Last) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Sp 21. Signatur of F NO155 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Pulmonary emboli enysician/ Medical resulting in death) Due to (or as a consequence of) Examiner cancer Se wentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury use as the burial-tran been signed by the attending physician and should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Pregnant at time of death Day 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown After this certificate has been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of funeral director, page 2 autopsy performed? Yes 2 No death? 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗹 No 1 🗌 Yes Certificate: To 1 YInpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Matural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation within 24 hours after death completed filled in by the 6 Could not be ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number RES-000 01/13/2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Good Samaritan Hospital 5601 Loch Raven Blud, Baltimore 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN19

DHMH 17 Rev 7/2009

Registrar

VE.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2010 Year Marjorie Kessack Tyler 12:25A M January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death ${\sf Annapolis}$ Examiner 4c. County of Death Anne Arunde 1 Anne Arundel Medical Center 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Days 1 □ M 2 🗓 F Months Hours 04-19-1928 403-32-3886 81 Country) Director KY Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD Anne Arundel Crofton 1 Yes 2 X No 10e. Street and Number ms 23a or must be r ò 10f. Zip Code 10g. Citizen of What Country? Funeral within 72 hours after death with 21114 U.S.A. 2239 Notely Lane items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Examiner Armed Forces?

1 Yes 2 No Black, White, etc. 9 þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural" Specify: white Completed 3 X Widowed 4 Divorced the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation permit. Page 1 and 2 should be filed within 72 l
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "n:
any injury or other traumatic event; the Medic 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Secretary Giant Food 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) r Corinne unknown Robert Kessack 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Douglas Tyler/Son 3364 Sudlersville S. Laurel, Maryland 20723 altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) West Arundel Crematory 01-15-2010 Odenton, Maryland sign ture of Funeral Servi 22. Name and Address of Facility
Donaldson Funeral Home & Crematory, P.A.
1411 Annapolis Road, Odenton, Maryland 21113 23a. Part 1. Enter the disease, of complications that cau shock, or heart failure. List only one cause on each complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) مه Medical Due to (or Lconsequence of Examiner Sequentially list conditions Examine if any, leading to immediate cause Enter In Julying Cause (Disease or linjury Due to (or as a co Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a cons Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day the 9 □ Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ nknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has be 2 s autopsy perform this certificate Yes 2 No 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? 1 Yes 2 **X**010 Other: ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Deat Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending Accident 1 ☐ Yes 2 ☐ No I Director: / Investigation Suicide Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practionar To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

DHMH 17 Rev 7/2009

State Registrar 29b. Signature and title of certified

MO

32. Registra Sign

Hung Tran Davis, MD 2011 Medical Park Annapolis, MD 21401

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D53111

29d. Date signed (Month, Day, Year)

10

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 7 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Medical Edward Tolson, Jr James Janu<u>ary</u> 2010 30 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 6178 Dorlon Drive Rock Hall Kent Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) 1 🕅 M 2 □ F Months Days Hours Min Month, Day, Year) /20/1928 220-20-3674 Director 81 Maryland Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD Kent Rock Hall 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6178 Dorlon Drive 21661 U.S.A. 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 X Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give 1 Yes 2 X No Specify: "natural" Completed 3 🗌 Widowed 4 🔀 Divorced Specify: White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 6 Truck Driver Transportation Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edward Tolson, Sr. Edna Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James <u>Tolson, III / Son</u> 2722 Night Fox Road, Greensboro, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 Other (Specify) Anatomy Gifts Registry 1/13/2010 Hanover, Maryland of Funeral Service Licens 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste P, Hanover, MD 23a. Part 1. Enter the disease, or complications that caused the depth. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to for as a possecuence of cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last signed by the attending physician and deed detached for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 LI Fetal usa.
Pregnant at time of death 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2 No Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has page 2 autopsy 1 Yes ANO 200 No Yes 25. Was case referred to medical filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? Other: ၉ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at After 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be within 24 hours after deat To the Funeral Director: 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 28f. Location (Street and Number or Rural Route Number, Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only on 29b. Signat and title of 29d. Date signed (Month, Day, Year) 1/13/10 00060301 ed cause of death (Item 23a) (Type, nd address of person w CHESTEN Jame, Mel State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

nd #18 per FH e900 2/5/10 TT
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 120 /Medical 4a. Facility Name (If not institution, give street and number) Town, or Location of Death County of Death Examiner andallstown If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 XM 2 ☐ F Director 918-48-393 July 03,1947 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylas Opertment of Heath and Martal Hygiene. Important; I flem 27 is marked other than "natural", or Items 23a or 28a-f show any injury; to rother traumatic event, the "hours in the most be notified any injury; or other traumatic event, the "hours". 1XYes 2 □ No Director Pikesville 10f. Zip Code MD Raltimore 10e. Street and Number 10g. Citizen of What Country? Sturgis filed within 72 hours after death 1 I Hygiene. by Funeral 801 Place 91908 USA 12. Was Decedent Ever in U.S Armed Forces? 1 Tyes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Probation Governmen OFFICER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Childs Ihemas Jaru 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Reral Route Number, City or Town, State, Zip Code) Tinetta Place Sturgis Pikesville, MD 21208 Pages 1 20b. Place of Disposition (Name of cemetery, crematory or other place) Date wK 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) e tro Crematory | 22. Name and Addres | Facility Baltimore, MD 21. Signatus | Fun ral Service Licen 1230 Midvalley Pr race 23a. Pant Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shook, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. Due to (or as a consequence of): Approximate Interval Betwo Physician /Medical Due to (or as a consequence of) Examiner Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the death certificate be executed signed by the attending physician and I be detached for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown or Attending Physician; The law requires that Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has e 2 autopsy After this certificate 2 No 1 ☐Yes 3 No 1 TYes funeral director, 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manne eath 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Aft completely filled in by the fun atural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 THomicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifler 29c. License number 29d. Date signed (Month, Day, Year) Reindallskun,

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 7 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2010 Month **Physician** DONALD WACHIER JR. January 17. 1:00 P M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Anne Arundel Linthicum Sweetser Road If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months, Day, Year) | Min. | March | 23, 1929 Birthplace (State or Foreign Country)
 New Jersey 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F 217-24-9706 80 **Director** Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show ed other than "natural", or items 23a or 28a-f shorevent, the Medical Evanimes must be sufficed as Maryland Linthicum Heights 1 ☐Yes 2 No Directo Anne Arundel 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 202 Sweetser 21090 Road U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 XYes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No ģ Specify: White 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Auto Sales 12 n Salesman Department of Health and Mental Hygis Important: If item 27 Is marked other any injury or other traumatic event, If once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bertha Krauss Donald Wachter Sr. ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Susan W. Koch (Daughter) 202 Sweetser Road, Linthicum Heights, Maryland 21090 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Bayview Crematory Jan. 19, 2010 Baltimore, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility McCully—Polyniak Funeral Home P.A 237 East Patapsco Avenue, Baltimore, Maryland 21225 23a. Pay . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, speck, or heart failure. List only ope cause on each line.

Im ediate Cause (Final disease or condition resulting in death)

a. Approximate Interval Between Onset and Death **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and ibe detached for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown been si should b Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No has autopsy 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P within 24 hours after death.

To the Funeral Director: After th
completely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number

State Registrar

31. Date filed (Month, Day, Year) 3 Segistrar's Signature

JAN 1 9 2010 Line J. Jane

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plete cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 00829 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ZUID Month Janhar **JOHN** W. WHIDDEN 4c. County of Death 4a. Facility Name (If not institution, give street and number) Town, or Location of Death If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Amade Anne Baltimore-Washington Medical Center Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Voarl 1 M M 2 □ F 579-36-5570 79 1930 Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10h County 1 □Yes 2 No Maryland 1 4 1 Anne Arundel Pasadena 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 8387 Oak Drive 21122 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ■Yes 2 □ No 14. Race - American Indian, 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) U.S. Gypsum 10 Maintence Mechanic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William E. Whidden Ε. Walker Celie 19a. informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Geraldine M. Ashe (Daughter) 8387 Oak Drive, Pasadena, Maryland 21122 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Crownsville VA Cemetery Jan. 22, 2010 Crownsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility McCully—Polyniak Funeral Home P.A. 3204 Mountain Road, Pasadena, Maryland 21122 21. Signature of Sur ral Service Lice Approximate Interval Between Onset and Death 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. mmediate Cause (Final nemmon disease or condition resulting in death) lie to (or as a consequence of): Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🗆 Ectopic pregnancy Year Month Day 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed 1 ☐ Yes 1 TYes 2 No 25. Was case referred to medica examiner? 26. Place of Death (Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Inpatient 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Vatural

Examiner Box 68760 certificate be P.O. of Vital Records, Division Hospital or Attending 24 hours after death.

Physician

/Medical

Examiner

Funeral

Director

show

Director

Funeral

Completed by

Be

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?7 Is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Modic Event in a modified at

and Mental Hygiene.

Is marked other than

permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 Is marked, any linjury or other traumatic evones.

Physician

/Medical

ending physician and use as the burial-tran

certificate has been signed by the atter irector, page 2 should be detached for u

ours after death.

neral Director: After this certific filled in by the funeral director,

within 24 hours a

Physician/Medical

2

Completed

Be

Certification: To

Medical

2 Accident

3 Suicide

29a. Certifier

4 T Homicide

(Check only one)

29b. Signature and

Baltimore, Maryland 21215-0036

5

State Registrar

title of certifie

6 ☐ Could not be

1 ☐ Yes 2 ☐ No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

of person who completed cause of death (Item 23a) (Type, 30. Name and addre

and manner stated.

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 8:50 AM January 16, 2010 John Wehner Ronald /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore White Marsh
If Under 1 Year | If Under 24 Hrs. 5730 Carrington Drive Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 M 2 □ F Maryland Director June 14, 1948 212-52-6491 61 Usual Residence of Decedent 10c. City, Town or Location 10d Inside City Limits r 28a-f show notified at 10a. State 1 ☐ Yes 2 No Director Ormond Beach Florida Volusia 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number ms 23a or 7 S. A.

14. Race - American Indian, 32174 Funeral 1217 Londonderry Circle th and Mental Hygiene. ? is marked other than "natural", or Items traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2X Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Public Schools 12 Carpenter 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဂ Barbara Schneider Wehner John 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 32174 1217 Londonderry Circle Ormond Beach, Florida item 27 other t Hope Wehner (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 2613 Department of Important: If it any Injury or c 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Bayview Crematory Baltimore, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Bruzdzinski Funeral Home 1407 Old Eastern Avenue PA Essex, Maryland 21221 23a. Part1. Enter the disease, or commications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) BRAINSTEM **Physician** /Medical Due to (or as a consequence of): Examiner MOS S. pentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of burial-trar Due to (or as a consequence of) physician a the burial Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 4□Pregnant at time of death 5 Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 2X No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Brother's Residence Other: 4 Nursing Home 5 Residence 6 MOther (Specify) 1 Yes 2 No Hospital: 1 🔲 Inpatient ۵ 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760 in 24 hours after use... the Funeral Director: Aft within 24 To the F

7

State Registrar

Medical

29b. Signature and title of certifier

29c. License number D16801

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29d. Date signed (Month, Day, Year) 17 JAN 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GUIRE 9103 Franklin Squere Tr. Baltone MT 21237

31. Date filed (Month, Day, Year)

29a. Certifier

0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death January 14 2010 1841 M **Physician** Komaune /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A **Baltimore City** The Johns Hopkins Hospital | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Days, Year May 28, 1 9. Birthplace (State or Foreign Country) New York 5. Social Security Number 7 Age (In vrs. last birthday) **Funeral** 1 □ M 2 F 192-38-3345 **Director** Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location 1 X Yes 2 □ No Collier FLNaples Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code 1733 Morning Sun Lane 34119 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11, Marital Status 1 Never Married 2 X Married 1 ☐ Yes 2 🛣 No Specify: White 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 4 Healthcare Nurse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles Gill Dorothy Stoddard 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1733 Morning Sun Lane, Naples, FL 34119 Charles E. Williams - Husband permit. Pages 1 and Department of Healt Important: If item 2 any Injury or other once, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3X Removal from State American Cremation 1-19-2010 Warwick, PA 4 Donation 5 Other (Specify) 22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd., Arbutus, MD 21227 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. not enter the mode of dying, such as cardiac or respiratory arrest, Interstitial Immediate Cause (Final Du/monany **Physician** disease or condition resulting in death) /Medical Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Due to (or as a consequence of): Medical IF FEMALE: 23d Date of delivery Month Day Year to use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 6 Other (Specify)

Examiner or Attending Physician: The law requires that the death certificate be executed after death. Box 68760. P.O. Division of Vital Records.

28a-f show

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items 23a

Pages 1 and 2 should be filed within 72 hours after death venent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23

Baltimore, Maryland 21215-0036

Injury or other traumatic event, the Medical Examiner

must be notified

Physician/	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown 3 Ectopic pregnan 5 Other (specify)	23d. Date of delivery Month Day Year
by	Part II. Other significant conditions	contributing to death but not resulting in the underlying cause	given in Part I. 23e. Did tobacco use contribute to the cause of death
Completed		·	24a. Was an autopsy avait prior to completion of caus death? 1 Yes 2 No 1 Yes 2 No
0	25. Was case referred to medical		26. Place of Death (Check only one)
P P	examiner? 1 ☐ Yes 2 X No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA	ther: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify)
rtification:	27. Manner of Death Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury W	ury at 28d. Describe how injury occurred ork? Yes 2 \sum No
Certific	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determined		28f. Location (Street and Number or Rural Route Number, City or Town, State)
cal			time, date and place, and due to the cause(s) and manner as stated. opinion, death occurred at the time, date and place, and due to the cause(s)

29b, Signature and title of certifier

29c. License number RES-000

29d. Date signed (Month, Day, Year) January 14, 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Peloquen

Peloquin

600 North Wolfe St, Baltimore, MD, 21287

State Registrar

24 hours

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death January 11, 201^{Year} William Willey 5:40 P M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death St. Mary's 7865 Traeleigh Lane Charlotte Hall 8. Date of Birth (Month, Day, Year) March 16,1914 5. Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Min. Days Months. Hours 1**X** M 2 □ F Delaware 95 March 213-07-4637 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b County 1 ☐ Yes 2 ☐ No Maryland St. Mary's Charlotte Hall 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20622 7865 Traeleigh Lane USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐XNo Specify: Specify: White 3 ☑ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Western Electric Supervisor 8 years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) George Dickerson Margaret Owens 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Granddaughter 7865 Traeleigh Lane, Charlotte Hall, Maryland 20622 Susan Porter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition January 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oak Lawn Cemetery 15, 2010 Dundalk, Maryland 21. Signature of Funeral Service Licensee ^{22. Name and Address of Facility}
Connelly Funeral Home Of Dundalk, P.A.
7110 Sollers Point Road, Dundalk, MD. 23a. Part 1. Enter the disease o complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. is only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □Yes 2 □No Month Day Year Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 □Yes 2 No 1 ☐Yes 2 ☐No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🖃 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred

Examiner Division of Vital Records, P.O. Box 68760

Attending Physician: The law requires that the death certificate be executed burial-tran attending physician for use as the buria signed by the a icate has been sig , page 2 should b certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certific completely filled in by the funeral director,

Physician/Medical

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Completed

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Certification: To

Medical

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evantinar must be notified at once.

Physician

/Medical

altimore, Maryland 21215-0036

1 ☐ Yes 27. Manner of Death 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar TZER

30. Name and address of person who con

32. Registrar's Signature

eted cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 00833 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ $20\overset{\text{Year}}{10}$ Barbara Williamson 10:20 AM January Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death Sunrise Assisted Living Columbia Howard 8. Date of Birth (Month, Day, August 18 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign Funeral Birting. Country Lowa 1 🗆 M 2 😿 F Director 512-28-1239 Usual Residence of Decedent show 10a. State 10b. County ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🛣 No Columbia Maryland Howard 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21044 6500 Freetown Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14 Bace - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes : If Yes, Give 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: 3 Divorced 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) should be filed within and Mental Hygiene. Homemaker Own Home marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Willard M. Gaines Esther Niece 19a. Informant's Name/Relationship (Type, Print) . Page 1 and 2 shou ment of Health and tant: If item 27 is m 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cathy Pelton (Daughter) 6329 Angel Rose Court Columbia, MD 21044 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Important: If if any injury or c 1 🖾 Burial 2 🗌 Cremation 3 🔲 Removal from State Arlington National Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 1-22-2010 Arlington, Virginia 21. Signature of Funeral Service License witzke funeral filmes, 5555 Twin Knolls Road Inc. Columbia, Maryland 21045 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 3 Years Immediate Cause (Final Physician/ Alzheimer's Disease disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami that the death certificate be executed burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last physician the burial Physician/Medical Division of Vital Records, P.O. Box 68760 38 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Dav Pregnant at time of death 5 Other (specify) Yes 2 No been signed by the sahould be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Osteoarthritis, Generalized Hospital or Attending Physician: The law requires 1 ☐ Yes 2 ☐ No 3 🔀 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Chronic Obstructive Pulmorary Disease 24a. Was an autopsy director, page 2 within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, pagr 2 No Yes 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 - Nursing Home 5 - Residence 6 - Other (Specify) Assited Living 2 X No P 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 🛚 Natural injury work? 5 Pending 2 🗌 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 XXCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 — Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D56531 January 13, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8600 Snowden River Paryway #301 Harry Li, MD, Columbia, Maryland 21045 31. Date filed (Month, Day, Year) **JAN 19 2010** State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death Decedent's Name (First, Middle, Last) Year Month Day PM Physician Onucia Sc. County of Death 30/C nnette /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner Baltimore City** The Johns Hopkins Hospital | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, T.2) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number 1 □ M 2 🗡 F **Funeral** Months **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County filed within 72 hours after death with the Maryland 10a. State 1 XYes 2 □ No 28a-f show BaltiMore **Funeral Director** Examiner must be notified 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number ŏ USA Elmora items 23a 14 Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No If Yes, Give Year or Dates: Black, White, etc 1 Never Married 2 Married Specify: Polack 1 ☐ Yes 2 XNo ō þ 3 Widowed 4 Divorced "natural", 16b. Kind of Business/Industry Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) of Health and Mental Hygiene.
Item 27 is marked other than "natul other traumatic event, the Medical College (1-4 or 5+) Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last) Maryland Pages 1 and 2 should be fill train of Health and Mental Hisant: If item 27 is marked other Be မ 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State lmora Ave Baltimore, sposition (Name of crep other p 20b. Place of D 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State ō 4 Donation 5 Other (Specify) 21. Signatury of Juneral Sey ico Licensee any Approximate Interval Between Onset and Death Part . Inter the 159 se, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line. Thrombotic thrombouy topenic Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23d Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy Year Month Day in the past 12 months? Pregnant at time of death 5 Other (specify) 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 TYes 26. Place of Death (Check only one Hospital or Attending Physician: 25. Was case referred to medical Be examiner? Other: 3 DOA 4 - Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 1 ☐ Yes 2 No မ 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day) 28b. Time of 27. Manner of Death Certification: Injury 1 Natural 2 Accident 5 Pending investigation 1 🗌 Yes 2 🗌 No 28f. Location (Street and Number or Rural Route Number, 24 hours after deat Funeral Director: 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined 3 🗌 Suicide within 24 hours after dea

To the Funeral Director

completely filled in by th City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cal (check only one) Medic the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Janua Kelogrun

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

JAN 19 2010 Server &

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

600 North Wolfe St, Baltimore, MD, 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	te of Maryland /	Depar <i>Certi</i>	tment <i>ificate</i>	of Health of Deat	n and M h		eg. No.	00835
ı	Physicia	n	Decedent's Name (First, Middle, Last)	13.0					2. Date of Deal Month	Day Year	3. Time of Death 9:00 A M
	/Medic	al .	GEORGE HIRAM WINSTE 4a. Facility Name (If not institution, give street a			4b. Citv. To	own, or Location	on of Death	January	18, 2010 4c. County of Dea	
	Examin	er	340 Cokeland S.	,		Laur				Anne Aru	
	Funeral Director		5. Social Security Number 6. Sex 1 M 2 E	7. Age (In yrs. last b		If Under 1 Months	Year If Und Days Hour	der 24 Hrs. rs Min.	8. Date of Birth (Month, Day) June 15	; Yea <i>r) Co</i>	thplace (State or Foreign buntry) hington, DC
	D .		Usual Residence of Decedent		1	41					10d. Inside City Limits
	show	'n	10a. State 10b. County	10c. City, Tov		ition					1 □Yes 2□No
	the M	rect	MD Anne Arunde 10e. Street and Number	el Laur	reı	10f. Zip (Code		1	0g. Citizen of What Co	
	3a or	io le	340 Cokeland S.				20724			U.S.A.	
	ems 2	Funeral Director		s Decedent Ever in U.S. ned Forces?	13. Wa	as Decede Yes, speci	ent of Hispanic fy Cuban, Mexi	Origin? (Spe	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit	
36	be filed within 72 hours after death with the Maryland that Hyglene. do other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at	by F.	1 Never Married 2 Married 1 1	Yes 2 No 1948 es, Give ar or Dates: -1952	1[□Yes 2	TXNo <i>Sp</i> ec	cify:		Specify: W	hite
Š	2 hou		15. Decedent's Education	16			Occupation	nact of warki	70	16b. Kind of Business	/Industry
21215-0036	ithin 7 ne.	Completed	(Specify only highest grade comp Elementary/Secondary (0-12) Col Grade 12	lege (1-4or 5+)	life. DC	O NOT use	k done during n e retired)	nost of work	ng	3 M c M	
	filed w Hygier Sther th		17. Father's Name (First, Middle, Last)		Engi	neer	18. Mo	other's Name	(First, Middle,	AT&T Maiden Surname)	
an	should be f and Mental s marked ol umatic eve	To Be	Alton Winstead					ulah I	•	,	
Maryland	s 1 and 2 should be if Health and Menta item 27 is marked other traumatic ev	-	19a. Informant's Name/Relationship (Type. Prin	nt) 19	b. Mailing	Address	(Street and Nu	mber or Rura	al Route Numbe	r, City or Town, State,	Zip Code)
	es 1 and 2 of Health a item 27 is r other tra		Imogene Winstead				and S.	_		land 20724	-
ore e			20a. Method of Disposition 1 ☐ Burial 2 🛣 emation 3 ☐ Remova	I from State 20b. Place cemet					Date	20c. Location - City or	
altımore,	permit. Page Department of Important: If any Injury or once.	1	4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee	W. Ar			ematory Address of Fa			Odenton,	Maryland
n n	Impo any once	i, di	16 Ton	_ / M00770			albott i		Home, P	.A. 1, Marylan	d 20707
ı			23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one caus	s that caused the death. Do	o not enter	r the mode	of dying, such	n as cardiac	or respiratory ar	rest,	Approximate Interval Between Onset and Death
	Physician			Esophageal Ca	ancer						Oliset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequence	e of):						
	757	Jer	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	Due to (or as a consequence	e of):						
	ecuted ind transit	Examiner	triat irritiated events C.								
8760,	certificate be executed iding physician and se as the burial-transit	al Ex	resulting in death) Last	Due to (or as a consequence	e ot):						
687	ificate g phys	edical	d								
ROX	eath certific attending p	M/us	23b. was decedent pregnant 4 F	es, outcome of pregnancy	ith 3□	Ectopic pr	regnancy			23d. Date of de	
O.	ne death the atten hed for us	Physician/Me	in the past 12 months?	Pregnant at time of death Unknown		Other (spe				Month	Day Year
J.	w requires that the de been signed by the should be detached		Part II. Other significant conditions contributing	ng to death but not resulting	in the und	derlying ca	ause given in Pa	art I.	23e. Did to	bbacco use contribute	to the cause of death?
Records,	quires en sigr uld be	ed by							1 □ Y	′es 2 ∐ No 3 XX	Probably 4 Unknown
မင္ပဝ	2 33 a	Completed							24a. Was autop	sy prior to	utopsy findings available completion of cause of
	The ate pag	Con	-21.5-5-0.55.275-5-0.05-25.45.46.53.00						perfo	rmed? death? 2 XXo 1 ☐ Ye	s 2 🛛 N o
Vital	Physician: The this certificate al director, pag	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ Xo Hospita	l: 1 ☐ Inpatient 2 ☐ ER/0	Outpotiont	2□00	Othori		h (Check only o	ne) dence 6 □Other (Sp	anifed
to t		n: To	27. Manner of Death 28a		. Time of Injury		8c. Injury at Work?		-	now injury occurred	ecny)
Sior	Attending r death. ector; Afte by the fune	catio	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be			М	1 □ Yes 2	2 □No			
Division	- 000	Certification: T	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e	Place of Injury - At home, building, etc. (Specify)	farm, stree	et, factory,	, office		28f. Location (S City or Tox	Street and Number or F vn, State)	Rural Route Number,
21	tospita 4 hours funera ely fille	Medical C	(Check only 2 Medical Examiner: O	To the best of my knowled in the basis of examination and manner stated.	lge, death and/or inve	occurred estigation,	at the time, dat , in my opinion,	te and place, death occur	, and due to the red at the time,	cause(s) and manner date and place, and du	as stated. ue to the cause(s)
	To the within 2. To the Complet	Me	29b. Signature and title of certifier			29c	. License numb	per		29d. Date signed (Mor	nth, Day, Year)
			Jeather Le	M.D.			D 006	1885		January 1	8, 2010
			30. Name and address of person who complete Heather Lee, M.D. 49	ed cause of death (Item 23a 901 Telsa Dri			A. Bo	wie. M	larvland	20715	
Ş	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's Signature	,	24166	11, 100	F.	ar y rand		
	Registr		JAN 19 2010 /2.								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 00836 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Helen June Weininger 12:20A^M <u>January</u> 201<u>0</u> Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Co. Gilchrist Nursing Home Towson 8. Date of Birth (Month, Day, Year)
Aug. 9.1926 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Months Days 1 □ M 2 🖫 F Hours Min. Director Yrs 214-20-1347 Marvland Usual Residence of Decedent 3a or 28a-f show be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore City 1 Yes 2 No MD N/A 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 21224 United States 800 S. Eaton Street death with "natural", or items 23 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: 3 X Widowed 4 ☐ Divorced Specify: White Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation. 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Years Telephone Co. Clerk Communications Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Lucy Melson William Sims 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21152 29 Meadow Run Circle Sparks, Maryland John E. Weininger (Son) 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from Sta Other (Specify) 1/14/2010 4 Donation Oak Lawn Cemetery Baltimore, Maryland 21, Signature Meral Service Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, 7922 Wise Ave Dundalk. Marvland Part 1. Enter the disease, or complications that caused the seath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Due to (or as a consequence of) disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): burial-transit and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical or Attending Physician: The law requires that the death certificate be P.O. Box 68760 for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Day Month Year Pregnant at time of death the g Unknown detached To the Hospital or Attending Physician: The law requires that the within 24 hours after death.

To the Funeral Director: After this certificate has been signed by completed filled in by the funeral director, page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 🕅 Probably 4 ☐ Unknown Completed Dalmoury 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 □ Nursing Home 5 □ Residence 6 🕱 Other (Specify) ルンソンド 2 🗆 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27, Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 2 Accident 5 Pending work' 1 Tes 2 No Investigation 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number D 58303 29b. Signature and time of certifie 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 7/2009

State Registrar

DV

6701 N. Chorles ST Tan XN MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AMON

31. Date filed (Month, Day, Year)

CHARLES M)

10, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician 12, 6:00pM 2010 January Adrianna Genevieve Wenck /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Greater Baltimore Medical Center 5. Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) Baltimore County Towson 8. Date of Birth (Month, Day, Year) Jan 8, 2010 Birthplace (State or Foreign Country) **Funeral** Min. Months Davs Hours 1 □ M 2 ⋤ F Maryland Director n/a Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10h. County 10a State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 1 ☐ Yes 2 ▼ No Director Columbia Md. Howard 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21045 USA 6255 Deep Earth Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give' Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify þ White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) n/a n/a 0 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Tiffany Bennett Joseph Wenck 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 30 Charlcote Place Baltimore, Md. 21218 Mr. Douglas Bennett/ Grandfather 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specific OMD MC n 1-16-2010 Baltimore, Md. Oak Lawn Cemetery 21. Signature of Funeral Service Licenses 22. Name, and Address of Facility Funeral Home, Inc. 1050 York Rd. Towson, Md..21204 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 5 day= **Physician** Trigomy 18 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Unsease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician and for use as the burial-transit Exami The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 3 Ectopic pregnancy Year Day 5 Other (specify). signed by the a P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown After this certificate has been si funeral director, page 2 should I Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No 24a. Was an autopsy 2 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient 2 After this 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

al or Attending F s after death. neral Director: / e Hospital of 24 hours at the Funeral D To the within 2

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ASKI ANNA

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier NICE PEDIOTATION D36680 W

1 / Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

30. Name and order of person who completed cause of death (Item 23a) (Type, Print)

6701 North Charles St., Baltimore, MD 21204 Livemon MA 32. Registrar's Signature 31. Date filed (Month, Day, Year)

State Registrar

Medical

2010

David Lee Zoep	fl	1- For State	te of Maryla		artment of		nd Mental I			20	In	00838
Physicia	an/	Registrar 1. Decedent's Name (First, Middle,	Last)			Dodin		2. Date of De		Les V	$\stackrel{\cdot}{\dashv}$	3. Time of Death
Medical Exami		David Lee Zoe						Month January	Day 12, 201	Year 0		1225 hrs
Y		4a. Facility Name (if not institution, 3559 4th Street	give street and nur	mber)		b. City, Town, Balitmore	or Location of Dea	ith	4c.	County of I		
Funeral Director		CAK	Sex M 2 F	7. Age (In yrs. I 42			ear If Under 24H ays Hours M	_			Foreign	
		213-86-1262 Usual Residence of Decedent	M 2 F		Yrs						Cou	ntry)
any		10a. State 10b. County		10c. City,	Town or Locati			· · · · · · · · · · · · · · · · · · ·			Т	10d. Inside City Limits
JAC Show	ō	MD Balt:	imore		F	ialethoi	rpe					1 Yes 2 No
vith the Maryland s 23a or 28a-f show s	Director	10e. Street and Number)			10f. Zip Code			-	en of What		•
vith th		1938 Victory I		edent Ever in U.	S 13 Wa	L	21227 Hispanic Origin? (Specify Yes or N		1 Race :		an Indian, Black,
death v rritem	Funeral	1 Never Married 2 Marr					an, Mexican, Puer			White, e		
s after raf", o	by F		or Dates:				No specify:			Specify:		ite
2 hours	ted	15. Decedent's Education (Specific Elementary/Secondary (0-12)	only highest grade College (1-				pation (Give kind of ife. DO NOT use re		16b. Kir	nd of Busir	ness/In	dustry
036 ithin 7, ne. r than	Completed	12	July 1	, 0, 0,	Co	ntracto	or			Cons	tru	ction
15-0 filed w Hygie d othe		17. Father's Name (First, Middle, La				-	18.Mother's Nam	ne (First, Middle, cia Ann			~	
212' uld be Mental marke	To Be	Felix Robert 2 19a. Informant's Name/Relationship			19b, Mailing	Address (Stre	eet and Number or					Zip Code)
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		Monica Zoepfl -	- Sister				y Drive,					•
or Heal		20a. Method of Disposition 1 Burial 2 **Cremation**	3 Removal fro	m State	Place of Disposi crematory or oth	er place)		Date	20c. Lo	ocation - Ci	ity or T	own, State
timent trant:		4 Donation 5 Other Spec	orfy:	Wes			natory 1-				-	Maryland
Bal permi Depar Impo injury		21. Sign have of Full-eral Service Lik	sersee (20			ess of Facility Amohur Spri					
Physician		23a. Part I. Enter the disease, or co failure. List only one cause on		used the death.	Do not enter th	e mode of dyin	g, such as cardiac	or respiratory ar	rest, shock	k, or heart		Approximate Interval Between Onset and
Examiner	i	Immediate Cause (Final disease or condition resulting in death)	_a Myocard			complic	ating se	izure di	sord	er		Death
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	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a	consequence of	f):							
sd sit	dical Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a c	consequence of	f):							
.O. Box 68760, that the death certificate be executed ned by the attending physician and detached for use as the burial - transit	ical	XUNPENDED	d. #	5perFH,	G901,37	22/10, v	WS		0.410		\dashv	
60, ate be		IF FEMALE:	1	Pi line utcome of pregr		7,28a-f	perm,E	g901 3/1		TT Date of de	livery	
687 certific nding p	ian/	23b. Was decedent pregnant in the past 12 months?	1 Live bir	th nt at time of dea	ath -	al death 3	Ectopic pregn	nancy		fonth	Da	y Year
Box death the atte	Physician/Me	1 Yes 2 No 9 Unkno	7		atti 5 Oth	er (Specify)						
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of Vital Records, P.O. ing Physician: The law requires that th After this certificate has been signed by uneral director, page 2 should be detach								1 Ye				psy findings available
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I Re n: The tificate or, pag	S C	25. Was case referred to medical	Τ			26 Plac	ce of Death (Check	1 Yes	2 No	1 🗸	Yes	2 No
Vita nysician this cer		examiner? 1 ✓ Yes 2 No	Hospital: 1 In	patient 2	ER/Outpatient		Othor:		Residence	ce 6 🗸 (Other: \$	Scene
Division of Vital Records, P.O. tal or Attending Physician: The law requires that Irs after death. *I Director: After this certificate has been signed by led in by the funeral director, page 2 should be detaal.	Ë	27. Manner of Death 1 Natural 5 Panding		f Injury Day,Year)	28b. Time of In	·	jury at Work?	28d. Describe	how injury	occurred		
Siol Attend r death ector: by the	catio	2 Accident Investig	ation 9/13/		9:24 pm		Yes 2X No	unk	Street and	Number	or Pura	I Poute Number City
Divi	Certification:	3 Suicide 6 X Could n determine	ot be	Bar	me, raim, stree	, ractory, office	bulluling, etc.	or Town, S	etho	ll"Ha rpe,	immo MD	Route Number, City nds Ferry
Division of Vital Reco To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page 2	edical C	29a. Certifier 1 Certifying Phys	ician: To the best ner:On the basis of	examination ar				d due to the caus	se(s) and	manner as	stated	
To viii	Me	29b. Signature and title of certifier	and manner sta	ited,		29c. Licen	se number		29d. Da	ite signed	(Monti	n, Day, Year)
		Carol	Hall	an	22-1	0.0	.M.E.		Janua	ary 13, 2	:010	
AV			tant Medical E	xaminer	111 Penn S	treet, Baltin	nore, MD 2120	01				
Sta Regist	ate rar	31. Date filed (Month) Pay (Yelf)	2010 32. R	istrar's Signatui		ales						
DUMU 17 Day 1/20	001		OCME		7							

			For State Registrar	State of Maryland		artment of H			ene 2010	00839
	Physici	an	1. Decedent's Name (First, Middle, I	•				2. Date of Death		3. Time of Death
فالانطا	/Medic	cal	Helen Ruth Zim 4a. Fecility Name (If not institution, g			4h Cihi Tourn or	Location of Death	Jan. 13	2010 Year 4c. County of Death	7:00 AM
	Examir	ier	12 Glendorian	· ·		Cockeys			Baltimore	2
	Funeral			Sex 7. Age (In yrs. Ia	• • •	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye	ear) 9. Birthi	place (State or Foreign
,	Director		290-22-4844 Usuel Residence of Decedent	10 M 2 KF 82	Yrs.			Sept. 19	1927 (Ohio
	ryland how		10a. State 10b. County	10c. City,	Town or Lo	cation			1	10d. Inside City Limits
	Ba-fa	ctor	MD Baltim	ore Cock	ceysvi	11e				1 ☐ Yes 2 ☐ No
	eath with the Marylan s 23a or 28a-f ahow nest be notified at	Funeral Director	10e. Street and Number 12 Glendorian C	_		10f. Zip Code		10g.	. Citizen of What Cour	ntry?
	has 23	eral	11. Marital Status	12. Was Decedent Ever in U.S	. 13. \	21030	spanic Origin? (Sp	ecify Yes or No-	USA 14. Race - Americ	ean Indian
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other then "naturel", or items 23a or 28a-f ahow any injury or other treumatic event, "he Medical Examinating the molified at once.	ρ	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces?		Vas Decedent of His f Yes, specify Cubar □ Yes 2∑ No	Specify:	Rican, etc.)	Black, White,	
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121	within ine.	m p	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	OO NOT use retired))			
0 0	filed v Hygie other t		17. Father's Name (First, Middle, La	at)	Sp	ecial Cle		Te e (First, Middle, Mai	lecommunic	ations
lan	uld be dental rked c	To Be	Theodore Char	les Thieman			Helen	Louise	A. Zin	ıke
Maryland 21215-0036	2 shou and h Is ma		19a. Informant's Name/Relationship	(Type, Print)			nd Number or Run	al Route Number, C	ity or Town, State, Zip	Code)
	1 and Health Im 27 Ther tr		Todd Mark Zimme 20a. Method of Disposition			Spiral Cu sition (Name of			lumbia, MD	
Baltimore,	ages int of h t; If ite		1 ☐ Burial 2X Cremation 3	☐Removal from State cen	netery, cren	natory or other place)		c. Location - City or To	
Ħ	nit. P vartme ortani injury		4 Donation 5 ☐ Other (Spec	. / / / /		Cremator Name and Address	1		en Burnie,	
ä	Depa Impo any in		Fryan V. Cla						ey Valley, , MD 21093	Inc.
	Medical Examiner	iner	23a. Part1. Enter the disease, or co shock, or eart faure. List on Immediate Cause (Fival disease or con their resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury)	a	ence of):		73 /	CANCINON		Approximate Interval Between Onset and Death
68760,	icate be executed physician and s the burial-transit	dical Examiner	that initiated events resulting in death) Last	c	nce of):					
.O. Box	that the death certific ed by the attending p detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 22 No 9 ☐ Unknown	23c. If yes, outcome of pregnand 1 □ Live birth 2 □ Fetal d 4 □ Pregnant at time of dea 9 □ Unknown	eath 3 🗆	Ectopic pregnancy Other (specify)			23d. Date of delive Month	ory Day Year
ırds, P	The law requires that the te has been signed by the page 2 should be detache	þ	Part II. Other significant conditions	contributing to death but not resulti	ng in the un	derlying cause giver	n in Part I.	23e. Did tobacc	co use contribute to the	
al Record		Completed			_			24a. Was an autopsy performed	prior to cor death?	psy findings available inpletion of cause of
Vita	Physicien: r this certifica ral director, p	o Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ EF	VOutpatient	Other		(Check only one)	4 CO. 10 1	
1 0	<u>a</u> = <u>a</u>	n: To	27. Manner of Death	28a. Date of Injury 28	8b. Time of	28c. Injury	at	me 5 X Hesidence 28d. Describe how in	e 6 □Other (Specif) njury occurred	")
300	Attending F r death. ector: After by the funera	atlo	1 Natural 5 Pending investigation		Injury	M 1 Y	es 2 No			
Division of	r a r = c	Certification:	3 Suicide 6 Could not 4 Homicide determine		e, farm, stre	et, factory, office		28f. Location (Street City or Town, St	t and Number or Rura tate)	l Route Number,
	To the Hospital of within 24 hours at To the Funerel D completely filled in	edical Ce	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the best of my knowle miner: On the basis of examination and manner stated.	edge, death n and/or inv	occurred at the time estigation, in my opi	e, date and place, a nion, death occurr	and due to the cause ed at the time, date	e(s) and manner as st and place, and due to	ated. the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier	11.5		29c. License	number	29d.	Date signed (Month, I	Day, Year)
	5		1/Manh	UA Inine,	M.1	D. D.	1787	3 J	annans 1	4,2010
1	71		30. Name and address of person who	completed cause of death (Item 2:	3a) (Type, P	Vorth	Chan	los St	Towson	4,2010 1,MD2/204
	Sta Registra		31. Date filed (Month, Day, Year)	32. Ağıstrar's Signatur	1	. 40. 11				
			AIIII - V C	UIU MALLEN J		UKO/				

DHMH 17 Rev 1/2001

		1- For State Crimaryiand / Department of Health and Me Registrar Certificate of Death	ntai riygiche	ZUII Reg. No.) 00040
Physici			2. Date of Month	Day Year	3. Time of Death
Medical Exam	iner	VIVIAN OUSEPHINE BAINS		y 3, 2010	1000 hrs
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location 604 K. Street Oakland	n or Death	4c. County of Deal	ın
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Un	ider 24Hrs. 8. Date o	f Birth (MM/DD/YYYY) 9. Bi	rthplace (State or
Director		163-12-1254 1 M 2XF 90 Yrs. Months Days Hou		09/1919 Fore	gn ^{ountry)} PA
w any		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	tor	MD Garrett Mtn. Lake Park 10e. Street and Number		Transaction and the	1 X Yes 2 No
e Mar. or 28a	Director	10e. Street and Number 10f. Zip Code		10g. Citizen of What Cou	
vith th s 23a s notif	<u> </u>	604 K Street 21550 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic O	nain? (Specify Yes a	United Sta	ites rican Indian, Black,
eath y items	Funeral I	1 Never Married 2 Married 1 Yes 2 X No			noan maian, black,
after d	by Fi	3 X Widowed 4 Divorced of Dates: 1 Yes 2 X No 1 Yes 2 X No specifications of Dates:	5 y:	Specify: Whi	te
nours a	q pe			16b. Kind of Business	/industry
36 n 72 h nan "r ical E	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	r aso remedy		Business
Withingrene	E	12 Owner/Operator	er's Name (First, Midd	Mining E	quipment
215. e filed tal Hy ked of	BeC	John Pascarella unk	cnown	ile, Maiden Guriame)	
MD 21215-0036 nd 2 should be filed within 7 thin and Mental Hygiene. m 27 is marked other than aumatic event, the Medica.	ToE	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Nu		Number, City or Town, State	e, Zip Code)
MD d 2 sh lth and n 27 is		Jack Burns, Stepson 1753 Scranton Ter	race, The		
re, slan fHeal fiten		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City of	Town, State
Page:		4 Donation 5 Other Specify: Cumberland Crematory	01/05/200	1 10 39 Cumberlar	nd, MD
Baltimore, permit. Pages I ar Department of Hea Important: If ite	1	21. Signature of Funeral Service Licensee 22. Name and Address of Facil	litv		
		Ratherine Sweether 21 N. Second	l Št., Oak	ral Home, P.A land, MD 2155	
Physician /Madical	0 0	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as failure. List only one cause on each line.			Approximate Interval Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death) a. <u>Hypertensive atherosclerotic care</u> Due to (or as a consequence of): complicated by hy		ar disease	Deau
		Sequentially list conditions, b.	podiidimia		
	iner				
	Examine	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
OX 68760, anth certificate be executed attending physician and or use as the burial - transit			. / 1 0 / 1 0 mm		
be exe	Medical	X AMENDED 23a,27,28a-f,permE, g900 2 20b, per DVR g899 1/19/10	2/18/10 TT TT		
3760 ficate g phys s the b	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the		23d. Date of deliver	
x 68 h certi endin	Physician/	past 12 months? 1 Live birth 2 Fetal death 3 Ectop 4 Pregnant at time of death 5 Other (Specify)	pic pregnancy	Month	Day Yea r
BOy e death the att	hysi	1 Yes 2 No 9 Unknown 9 Unknown			
that the coned by the detached	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in P		id tobacco use contribute to	
S, P					bably 4 🗹 Unknown
cords,	Completed			ntopsy prior to	utopsy findings available completion of cause of
Rec The la	팃		1 V Ye	erformed? death? es 2 No 1 ✓ Y	es 2 No
tal Recision: The section of the sec	Be	25. Was case referred to medical examiner?	n (Check only one)		
f Vi Physical dir	욘	Thospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other 1 Inpatient 2 ER/Outpatient 3 DOA Other 2 Inpatient 2 ER/Outpatient 3 DOA Other 2 Inpatient 2 ER/Outpatient 3 DOA Other 2 Inpatient 2 ER/Outpatient 3 DOA Other 2 Inpatient 2 Inpatient 2 ER/Outpatient 3 DOA Other 2 Inpatient 2 Inpatient 2 Inpatient 2 Inpatient 2 Inpatient 2 Inpatient 2 Inpatient 2 Inpatient 2 Inpatient 2 Inpatient 3 DOA Other 2 Inpatient 2 Inpatient 2 Inpatient 3 DOA Other 2 Inpatient 2 Inpatient 3 DOA Other 2 Inpat	Nursing Home 5	Residence 6 Othe	r: Scene
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Certification:	1 Natural 5 Pending Ed 1/3/10 Ed 0.40 am 1 Yes 2	K _{No} subje	ct exposed to	o cold
IVISIOI or Attene after death Director:	icat	2 X Accident Investigation 28e Place of Injury - At home, farm, street, factory, office building is		onment n (Street and Number oc Ru n. State) 604 K	ral Route Number, City
Div	Ē	Suicide 6 Could not be determined (Specify) residence		n, State) 604 K nd, MD	Street
Hosp 24 hor Fune	_ 1	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and p			ed.
DIVI: To the Hospital or A within 24 hours after To the Funeral Dire completely filled in t	Medica	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death o	occurred at the time, da	ate and place, and due to th	e cause(s)
	Σ	29b. Signature and title of certifier 29c. License number	r	29d. Date signed (Mo	nth, Day, Year)
		Oiclor falle feel O.C.M.E.		January 4, 2010	
1.		30. Name and address of person who completed cause of death (Item 23a) Victor Weedn MD JD Assistant Medical Examiner 111 Penn Street, Baltimor	re MD 21201		
<u>V</u>	ate				
St Regist					

DHMH 17 Rev 1/2001

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ORIGINAL

			n #2 per 01/08/2010						delible Ir artment o			-		Legible.	008	41
			1 - State Registrar					Cei	rtificate d	of Dea	ath		Reg. No	D.		
		- 1	1. Decedent's Nam	e (First, Mida	lle, Last)							2. Date of D		ay Year	3. Time o	f Death
	Physicia Medic		Marion_	r. Chuy	way							Januar Decemb	dr 3	3, 2010	6:20	_ P ^M
1	Examin		4a. Facility Name (If not institution	on, give street	and number)			4b. City, Tow	n, or Loca	ation of Death		40	c. County of Dea	th	
			Goodwil.						Grant		1e Under 24 Hrs.	10 Data - 4 D		Garrett		F
	Funeral		5. Social Security N		6. Sex 1 ☐ M	2X1F	ge (In yrs. las	st birthday) Yrs.	If Under 1 Ye Months Da		ours Min.	8. Date of B	ay, Year	Co	thplace (State ountry)	_
	Director		209-03-		İ	9	92					May 5	19.	l/ Pen	nsylvar	lia
	land ow at		10a. State	10b. County	у		10c. City,	Town or Lo	ocation						10d. Inside C	ity Limits
	Mary First	ţ	MD	Gar	rett		Gra	ntsvi	111e						1X Yes	2 □ No
	with the Maryland a or 28a-f show be notified at	Director	10e. Street and Nu	mber					10f. Zip Coo	de			10g. C	itizen of What Co	ountry?	
	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show he Medical Examiner must be notified at	alD	891 Dor	sey Ho	tel Ro	ad			2153	36			Uni	ited Sta	tes	
	ours after death v ral", or items 23a Examiner must	Funeral	11. Marital Status		12. V	Vas Decedent	Ever in U.S.	13.	Was Decedent If Yes, specify (of Hispar Cuban, M	nic Origin? (Sp lexican, Puerto	ecify Yes or N	io-	14. Race - Ame Black, Whit		
9	or its	Fu	1 □ Never Mar		rried 1	☐ Yes 2X Yes, Give	No		1 ☐ Yes 2 ☐X		pecify:	,		Specify:		
21215-0036	72 hours "natural", edical Exa	d by	3 Widowed			ear or Dates:		10. 5					1 405	Wh	ite	
5-("nath	Completed	(Spe	15. Decede cify only high	nt's Education est grade con	n npleted)	1	16a. Dece	dent's Usual Oo kind of work do DO NOT use re	ccupation one during	ı g most of worl	king	160.1	Kind of Business	Industry	
121	withir ene. than	ם	Elementary/Sec	ondary (0-12)	c	college (1-4or	5+)		mbler	aneu)			W	estingho	use	
	be filed within 72 ho ital Hygiene. dother than "natu event, the Medical	ပ္သ	8 17. Father's Name	(First, Middle	. Last)			ASSC	IIID I C I	18.	Mother's Nam	e (First, Middi				
ano) Be	Ludwick							М	lary Li	genza				
Maryland	d 2 should be filed very and Mental Hygie 7 Is marked other traumatic event, the	ဥ	19a. Informant's N			Print)		19b. Mailii	ng Address (Str			<u> </u>	ber, City	or Town, State,	Zip Code)	
S S	C 10 0 10		June Be	dont. 1	Daught	er			. Box 4				2154			
Baltimore,	s 1 and 2 f Health item 27 I		20a. Method of Dis	position				ce of Dispo	osition (Name o	f		Date	20c. l	Location - City or	Town, State	
a B	Page ent o nt: If i		1 ☐ Burial 2 4 ☐ Donation			val from State)	-	-		:01/0 Memor	7/2010 ial Pai	ok (Greensbu	ro. PA	
Ħ	artm bartm bortar Inju		21. Signature of F				, web		2. Name and Ad	ddress of	Facility					
B	permit. Pages 1 and Department of Health Important: If item 27 any Injury or other tr once.	(Y	W GHI	caire	. 11	Lei To	0		David 21 N.	A. B Seco	ourdock and St.	. Oakla	al Ho	ome, P.A MD 2155	Ó	
			23a. Part1. Enter shock, or he	the disease, d	or complication	ns that cause	d the death.	Do not en	ter the mode of	dying, su	uch as cardiac	or respiratory	arrest,		Approxima Interval Be	ite etween
	Physician	1	Immediate Cause	(Final	st only one ca	3 / e. 7	Do de	1100	and:	n P	la La		-		Onset and	Death
	/Medical		disease or condition resulting in death)	OII .	aL	Due to (or as	s a conseque	ente of):	CICCI		11170	101			1 -10	
A.	Examiner		Oti-ll-li-t		h (rener	ales	ell	ath	ero	scle	105:	5		yea	15
	D #	ner	Sequentially list co if any, leading to in cause. Enter Und	mmediate erlvina	, "	Due to (or as	s a conseque	nce of):							yea	_
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90,	The law requires that the death certificate be executed ate has been signed by the attending physician and bagge 2 should be detached for use as the burial-transit		resulting in death)	Lasi		Due to (or as	s a conseque	ence of):								
6876	icate be physicia the bu	by Physician/Medica			d											
9 ×	leath certific attending pl for use as f	Mec	IF FEMALE:													
Box	ath c	jan/	23b. Was deceder in the past 1:		1	f yes, outcome □Live birth	2 Fetal o	death 3	⊒Ectopic pregn					23d. Date of de Month	elivery Day	Year
0.	at the de by the a tached f	/sic	1 ☐ Yes 2 9 ☐ Unknow	Z-No		1□Pregnant a 9□Unknown	at time of dea	ath 5L	Other (specif	y)			.			
a	that the	Ph)	Part II. Other sign		tions contribu	iting to death	but not result	tina in the u	inderivina cause	e aiven in	Part I.	23e. Did	tobacco	use contribute	to the cause of	death?
ds,	signe signe					g			,g	3		1 [Yes	2 ⊡√ lo 3□F	robably 4]Unknown
Ö	v requir been si should b	Completed										04- 14/-		041- 141		o eveileble
3eC	has the law	du										24a. Wa	topsy rformed;?	prior to	utopsy findings completion of	cause of
al	iclan: The certificate he ector, page								dtvr			1□ Yes	2 21	lo 1 ☐ Ye		
Vital Records,	Attending Physician: r death. ector: After this certifics by the funeral director, I	Be	25. Was case reference examiner?		al Hospi	tal:				Other:	. 1	th (Check only				
Division or	Phys r this ral dii	٠ <u>۲</u>	1 ☐ Yes 25 27. Manner of Dea	No oth		1 ☐ Inpat 8a. Date of Inj		R/Outpatie	III 3 LOA		Nursing H			6 □Other (Sp jury occurred	ecity)	
on	ding h. h. After funer	Certification:	Natural	5 Pend		(Month, D		Injury		Injury at Work? 1 ☐ Yes	2 □ No					
Si	Atten deat ctor: y the	fica	2 ☐ Accident 3 ☐ Sulcide	6 ☐ Could	d not bo	Be. Place of in	ijury - At hom	ne, farm, st	reet, factory, of		_	28f. Location	(Street	and Number or F	Rural Route Nu	mber,
Ξ	after after Dire	erti	4 ☐ Homicide	deter	mined	building, e	etc. (Specify)					City or 7	own, Sta	ate)		
	To the Hospital or Attend within 24 hours after death. To the Funeral Director; /		29a. Certifier											(s) and manner		
	e Ho 1 24 the Fu ie Fu	Medical	(Check only one)	2☐ Medica		On the basis and manner s		on and/or ir	nvestigation, in	my opinio	on, death occu	irred at the tim	ie, date a	and place, and di	ue to the cause	(s)
	To the within 2 To the complet	ĭ.	29b. Signature an	d title of certif	ier	1/-			29c. Lie	cense nu	mber		29d. D	Date signed (Mor	nth, Day, Year)	
			166	haar	ax ac	Pau	-N			466	050		1	-4-2	004 8	2010
			30. Name and add	lress perso	n who comple	eted cause of	death (Item 2	23a) (Type,	Print)		/	2		,		
	1	VO	maras	eret	a ki	WEN	md	13	079 91	rive	d high	livee	16	-4-2	1. Md	21550
	Sta	ite	31. Date filed Mo				trar's Signatu	ire 🔏	Rosa	1	0					
	Regist	ar		JAR	1 - 520	IIU I	Browns	B.	The same of the sa							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2010 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death CRUICKSHANK Physician Month Day 3:00 P M JAN, 0 (2010 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Vantage House Columbia Howard If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1 M 2 X F 82 Director 216-20-4281 07/08/1927 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits Show p.m.ft. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 No Columbia MD Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5400 Vantage Point Road 21044 United States Funeral Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married timore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: White 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Francis York Lambert Lydia B. Smith 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2780 Thornbrook Road Ellicott City, MD Lydia C. Smith - daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Ardent Crematory 01/02/2010 | Hanover, MD 22. Name and Address of Facility
Harry H. Witzke's Family F.H.Inc 21. Signatur of funeral Service Licensee M01411 4112 Old Columbia Pike Ellicott City, MD 21043 Co-23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Cancer of Unknown **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequent e of) Examine burial-transit the death certificate be executed and Due to (or as a consequence of) P.O. Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records. 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2☑ No 24a. Was an perform 1□ Yes 2☑No Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA To the Houndal or Attending Pt within 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28h. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? 5 Pending investigation 1 ∏Yes 2 ∏No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier

ALAGEL, ND 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

Pay. Year)

parke

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 00843 State of Maryland / Department of Health and Mental Hygieney Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** 3, 2010 1:00 p ^M January Robert L. Colder /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 1407 Scanlan Drive Glen Burnie Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 08/09/1930 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 121 M 2 T F 79 MD 215-28-0839 Director Usual Residence of Decedent 10c. City, Town or Location 10d, Inside City Limits r 28a-f show notified at 10a. State 1 ☐ Yes 2 XNo Director MD Anne Arundel Glen Burnie 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number r than "natural", or items 23a or the Medical Examiner must be 1407 Scanlan Drive 21061 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian 11. Marital Status Black, White, etc. 72 hours after 1 Never Married 2 Married 1 X Yes 2 ☐ No If Yes, Give Year or Dates: Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White þ 3 XWidowed 4 ☐ Divorced Completed 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Microwave Technician permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: If Item 27 Is marked other I any Injury or other traumatic event, tt 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Otho Colder Catherine Killmeyer 19a, Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brian Colder - son 6900 McLean Province Cr. Falls Church VA 22043 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 01/06/2010 Baltimore, MD Loudon Park Cem. 21. Signature | Funeral Service Lice see 22. Name and Address of Facility Harry H. Witzke's Family F.H.Inc. M01411 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Blacker 10 years /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) I□Yes 2□No been signed by the should be detached 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an has autopsy or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Jother (Speciely) Post A Other: 4 Nursing Home 5 Residence To the Hospitar ... within 24 hours after death.

To the Funeral Director: After this c 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ٩ 6 28d. Describe how injury occurred 27. Manner of De 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) wern MO

Registrar
DHMH 17 Rev 1/2001

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

31. Date filed (Month, Day, Year) JAN 0 5 2010

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

JAN - 4 2010

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 01020 M 2010 KHTU 01 4c. County of Death 4a. Facility Name (If not institution, give street and number) ROCKVIL HOSPITAL MONTGOMERY SHADY GIROVE ADVENTIST Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) 1 □ M 2 💢 F 85 INDIA 247-91-084 OX Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 1XYes 2 □ No 10WSON MD 10g. Citizen of What Country? 10e. Street and Number 20 LAMBOURNE ROAD # 122 PAKISTAN 21204 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Asian 3 Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) OWN HOME MAKER 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) TALIMUNISA HASEENUDDIN 19a. Informant's Name/Relationship (Type. Print) 56 N - IN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) TOWSON, MD. 21204 20 LAMBOU 20b. Place of Disposition (Name of cemetery, crematory or other place) AL-FIRDAUS MEM. 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State AUS MEM. 01/01/2010 FREDERICK, MD. 22. Name and Address of Facility ADEN MUSLIM FUNERAL 4 Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee SER. 1242, EASY ST. WOODBRIDGE VA. 22191 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Respirata disease or condition resulting in death) Due to (or as a consequence of) Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ypertension Due to (or as a consequence of)

Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-trar Division of Vital Records, P.O. Box 68760, within 24 hours after death

To the Funeral Director:
completely filled in by the

Be Completed by Physician/Medical

Certification: To

Medical

29b. Signature and title of cert

Physician

/Medical

Examiner

Funeral

Director

ns 23a or 28a-f show

7 is marked other than "natural" traumatic event, the Medical Ex-

t of Health a

Department of Health Important: If item 27 any Injury or other to once.

Physician

/Medical

Examiner

Funeral Director

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Be Completed

the Maryland

Pages 1 and 2 should be filed within 72 hours after death with

Baltimore, Maryland 21215-0036

	den den	neutin			
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of o 9 ☐ Unknown	I death 3 🗆 Ectopic			23d. Date of delivery Month Day Year
Part II. Other significant conditions of	ontributing to death but not res	ulting in the underlying	cause given in Part I.		o use contribute to the cause of death? 2 No 3 Probably 4 Unknown
				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1
25. Was case referred to medical			26. Place of De	ath (Check only one)	
examiner? 1 ☐ Yes 2 DNo	Hospital: 1 Inpatient 2	ER/Outpatient 3 🗌	DOA Other: 4 Nursing H	Home 5 ☐ Residence	6 ☐ Other (Specify)
27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how in	jury occurred
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, street, factory)	ory, office	28f. Location (Street City or Town, Sta	and Number or Rural Route Number, ate)
29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of my knowner: On the basis of examinating and manner stated	owledge, death occurre ation and/or investigati	ed at the time, date and plac on, in my opinion, death occ	e, and due to the cause urred at the time, date a	e(s) and manner as stated. and place, and due to the cause(s)

29c. License number

D0057574

Registrar

20850 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. AHMED HESHMAT M.D WILD MOLECULAR DR. STE. 200, ROCKVILLE. MD

29d. Date signed (Month, Day, Year)

01

2010

32. Registrar's Signature 31. Date filed (Month, Day, Year)

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Cyrus Breyard D			of Maryland				and Ment	al Hygiene		2010	0001.0
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Medical Exami		Cyrus B.	Dirickson					Month January	Day 5, 2010	Year D	1337 hrs
		4a. Facility Name (if not institution, gi	ive street and number)			4b. City, Town,	or Location of			. County of Death	1
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Funeral		Social Security Number 6. 8	Sex 7. Ag	e (In yrs. la	st birthday)	If Under 1 Y	ear If Under	24Hrs. 8. Date of B	irth (MM/	DD/YYYY) 9. Bir	thplace (State or
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			AM ZUF	00	Yrs	·		12/1	//19	41 1	7世W York
any		Usual Residence of Decedent 10a. State 10b. County		10c. City.	Town or Locat	ion					10d. Inside City Limits
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15-0036 filed within 72 hours after death with the Maryland Hygiene. 4d other than "natural", or items 23a or 28a-f sho i, the Medical Examiner must be notified at once.		200 Creekside D	rive			218	304		Ţ	JSA	
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5-00 led wit Hygien other	ပိ	17. Father's Name (First, Middle, Las	•				18.Mother's	Name (First, Middle,	Maiden	Surname)	· · · · · · · · · · · · · · · · · · ·
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and 2 should feath and Me tem 27 is ma traumatic en		Deborah Diricks	on/spouse		20	O Creek	side D	r., Salisb	ury,	MD 2180)4
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.= = ~ 0		4 Donation 5 Other Specification 21. Signature of Funeral Service Lice		Cil							
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		or condition resulting in death)	Due to (or as a conse	equence of)	K.						
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Box 68760, e death certificate be exe the attending physician and for use as the burial.	an/Medi	IF FEMALE:	23c. If yes, outcor			HE 890	0 2/1/	710 11	230	d. Date of delivery	,
187 rtifica ing p	2	23b. Was decedent pregnant in the past 12 months?	1 Live birth	. •	2 Fe	tal death	3 Ectopic	pregnancy		Month D	ay Year
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To the Hos within 24 h To the Fur completely	Medical	one) 2 Medical Examine	er:On the basis of examination and manner stated.	mination an	d/or investigat	tion, in my opin	ion, death occ	urred at the time, date	and pla	ice, and due to the	e cause(s)
To To con	§ S	29b Signature and title of certifier	and mariner stated.			29c. Lice	ense number		29d [Date signed (Mor	nth, Day, Year)
		D m).				0.0	C.M.E.		Jani	uary 6, 2010	
		30. Name and address of person who	completed cause of d	eath /Itom 1	23a)						
		Donna M. Vincenti, MD	Assistant Medic			Penn Stre	et, Baltimo	re, MD 21201			
	ate	31. Date filed (Month, Day, Year)	_				-				
Regist		.IAN 13	2010 Denes	m ,	D. 40	ale					

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar#18. Certificate of Death per fh, 1/14/2010 tj amend item Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 22:59M Dise Τ., E1wood TANUARY Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Regional Medical Cent 8. Date of Birth (Month, Day, Year) 04-23-1930 Birthplace (State or Foreign Country) **Funeral** Months 1 **X** M 2 □ F Virginia Director 220-26-4005 Usual Residence of Decedent if Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Director 1 Yes 2 No MD Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5217 Sharps Point Road 21801 USA death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 X Yes 2 If Yes, Give Black, White, etc. 1 Never Married 2 Married ģ 2 🗌 No 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify: Specify: 3 Divorced 4 Divorced Year or Dates.Korea Completed White 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Sales Associate Plumbing Company 10 none Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Elwood L. Dise Audrey Dise Stephens permit. Page 1 and 2 should Department of Health and M Important: If item 27 is mar any injury or other traumat once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janet Brewington Dise/wife 5217 Sharps Point Road, Salisbury, MD 21801 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Shad Point Cemetery 101/05/2010 Shad Point, Maryland 4 ☐ Donation 5 ☐ Other (Specify) anature of Funeral 22. Name and Address of Facility Hinman Funeral Home -M00295 11673 Somerset Ave., Princess Anne. Part 1. Enter the disease, or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. ASCVA Onset and Death nmediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner CAD Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) burial-transit Cause (Disease or injury that initiated events and Due to (or as a consequence of): resulting in death) Last signed by the attending physician d be detached for use as the burial Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If ves, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Month Day Pregnant at time of death Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed After this certificate has been significate has been signification, page 2 should 24b. Were autopsy findings available 24a. Was an autopsy performe prior to completion of cause of death? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certifical completed filled in by the funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 2 Accident injury 5 Pending 1 ☐ Yes 2 ☐ No Investigation 3 Suicide
4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D29105 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Re State Registrar

		-	For State Registrar	01010 01110	Ce	ertificate of	Death	,	Reg. No.	1 0	00840
	Physicia		1. Decedent's Name (First, Middle, La	ist)				2. Date of De Month	Day	Year	3. Time of Death
-	Physicia /Medic		1 2	Duncan				Janua	cy 1 201		8:20 A M
- Proper	Examin		4a. Facility Name (If not institution, gi				or Location of Dea	th	4c. County		
wg."			Egle Nursing & R 5. Social Security Number 6.		r (In yrs. last birthda		coning	S. 8. Date of Bir	th Alle	gany 9. Birtho	lace (State or Foreign
	Funeral Director		220-28-9437	1 □ M 2 🔀 F 78		Months Days			3, Year) 3, 1931	Cour	zland
	and w	ŀ	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or I	Location				1	0d. Inside City Limits
	Maryl f sho	Ď	MD. Allegan	ıy	Lonacon	ing					1 X Yes 2 □ No
	r 28a	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of \		
	h with	a B	17007 Lower Georg	es Creek Ro	oad	2153	9		United	l Stat	ces
215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it c. Notical Examination and injury or other traumatic event, it c. Notical Examination and injury or other traumatic event, it c. Notical Examination and its confidence.	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent E Armed Forces? 1 Tyes 2 A If Yes, Give Year or Dates:	Ever in U.S. 13	B. Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 XNo		Specify Yes or No rto Rican, etc.)	Specif	ce - Americ ck, White, c y: wh i	etc.
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<u>8</u>	and 2 s ealth ar n 27 is ner trau		Cheryl Lea Farrel		r 1700	7 Lower C	eorges C	reek Rd,	Lonacon	ning,	MD 21539
altimore,	Pages 1 and 2 nent of Health ant: If Item 27 i ury or other tra		20a. Method of Disposition 1 ▼Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Spec		cemetery, ci	position (Name of rematory or other pi Hill Ceme		1/04/ 010	Barton,	,	
Ħ	permit. F Departm Importar any injur		21. Signature of Funeral Service-Lice			22. Name and Add	- -	Boal Fun	eral Hon	ne	27V
ñ	lmp per		> 7. Way	ne Son	e	111 Churc	h St, We				21562
Salar Marie	Physician /Medical Examiner	, L	23a. Part 1. Enter the disease of cor shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death)	Due to (or as a b.	the death. Do not ele. a consequence of): a consequence of):	Aritag	ying, such as cardi	ac or respiratory a	arrest,		Approximate Interval Between Onset and Death
	ted isit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	a consequence on.						
	execunal and all-tran	Examiner	that initiated events resulting in death) Last	c Due to (or as	a consequence of):						
68760,	e be	cal		d .							
	ih certificate be executed ending phystcian and ruse as the burial-transit	an/Medical	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		3 □ Ectopic pregna	nev			ate of deliv	
P.O. Box	the dea by the att	Physician/	in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	4 ☐ Pregnant at 9 ☐ Unknown		5 ☐ Other (specify)			IVI	onth	Day Year
~. o	s that med b e deta	by Pt	Part II. Other significant conditions			underlying cause (given in Part I.	23e. Did	tobacco use con	tribute to t	he cause of death?
ğ	quire en sig uld b	ed to	Hyvertens	in; D in cana	ernutur	· His-	tory	- 1 🗆	Yes 2 □ No	3 ☐ Prol	bably 42 Unknown
ပ္တ	aw re as bev 2 sho	Completed	of coli	n cana	7		•	24a. Was		Were auto	opsy findings available impletion of cause of
Ě	hysician: The law his certificate has b I director, page 2 sl	ĕ	U						ormed?	death? 1 ☐ Yes	` —
ita	clan: ertific ctor,	Be	25. Was case referred to medical examiner?					eath (Check only	one)		
<u></u>	hysic this c		1 ☐ Yes 2 ☐ XHo		ent 2 ER/Outpat	ilent 3 🗆 DOA		Home 5 ☐ Res			fy)
Ä	ling F	ion:	27. Manner of Death 1 Matural 5 □ Pending	28a. Date of Inju (Month, Da	ry 28b. Time y, Year) Injury	y W	juryat ∕ork? ∐Yes 2 ∐No	28d. Describe	how injury occur	rrea	
Division of Vital Records,	To the Hospital or Attending Physician: The law requires that the death ce within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attendit completely filled in by the funeral director, page 2 should be detached for use	Certification: To	2 ☐ Accident investigati 3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	be 280 Place of Inju	ury - At home, farm, c. (Specify)				(Street and Num own, State)	ber or Run	al Route Number,
	Hospit 24 hour Funera etely fille	edical (Physician: To the best aminer: On the basis o and manner sta	f examination and/or						
	To the To the To the To the To the To the	Me	29b. Signature and title of certifier			29c. Lice	ense number		29d. Date signe	ed (Month,	Day, Year)
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		4	30. Name and address of person wh			e, Print)					
		,	Dr. Jesus Tan, 4			3, MD 21	532	<u> </u>			
	Sta	ite	31. Date filed (Month, Day, Year)		ar's Signature	had					

	4	For State	State	n Marylan		rtificate of		and Mental H		/11	10	0084
	1	Registrar Decedent's Name (First, Middle	e. Last)		Ce	Tillicale of	Deam	2. Date of I	Reg. N Death	lo. L. U	, 0	3. Time of Death
hysician		Nellie Mae						Month Janua	D	3, 20	Year 110	11:45 AM
/Medical Examiner		a. Facility Name (If not institution		ımber)		4b. City, Town, o	r Location of			c. County		11.45 AT
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neral	5	. Social Security Number	6. Sex	7. Age (In yrs. i	-	If Under 1 Year Months Days	If Under Hours	24 Hrs. 8. Date of (Month,	Birth Day, Year	r)	9. Birthp	lace (State or Foreign
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eran		Jsual Residence of Decedent 0a, State 10b. County		10c. City	y, Town or L	ocation					11	Od. Inside City Limits
in in												1 ☐ Yes 2 🛛 No
any injury or other traumatic event, the Medical Exprinted right be nutfined at once. To Be Completed by Funeral Director		Maryland Ceci Oe. Street and Number	.1		E1kto	10f. Zip Code			10g. C	Citizen of W	/hat Coun	try?
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iner must be notified Funeral Director	1	1. Marital Status	12. Was Dec	edent Ever in U.	S. 13.	Was Decedent of H	lispanic Or	gin? (Specify Yes or		14. Race	- Americ	an Indian,
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t, the Medical E		15. Deceden (Specify only highes	t's Education st grade completed))	16a. Dece	edent's Usual Occup e kind of work done DO NOT use retire	oation during mos	t of working	16b.	Kind of Bu	siness/Ind	dustry
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art.		17. Father's Name (First, Middle,	Last)		I HO	omemaker	18. Mothe	er's Name (First, Mide	dle, Maide		<u>Hom</u> e)	e
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ımati		19a, Informant's Name/Relations			19b. Mail	ing Address (Street		er or Rural Route Nui		y or Town,	State, Zip	Code)
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directo	3	examiner? 1 Yes 2 No	Hospital:	Inpatient 2	FR/Outnativ	ent 3 DOA Oth	nor:	e of Death <i>(Check on</i> ursing Home 5 ☐ R		6 🗆 Oth	er (Specif	f ₍)
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letely filled in by the funeradical Certification:	- 1	29a. Certifier 1 Certifyir	ng Physician: To the	hasis of evamina	tion and/or i	investigation in my	oninion de	ath occurred at the tir	ne date a	and place :	and due to	o the cause(s)
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Completely filled in by the funeral director, page 2 should be detached for use as Medical Certification: To Be Completed by Physician/Medical Certification:		29a. Certifier (Check only one) 29b. Signature and title describe	ng Physician: To the	hasis of evamina	tion and/or i	investigation in my	oninion de	ath occurred at the tire	ne date a	and place :	and due to	Day, Year)

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene $2 \, \cap$ Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Physician/ Month Christine Ruth Evans 8:14 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Coastal Salisbury Hospice at Wico migo the Lake 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛣 F Hours Min. 88 213-22-6198 Director 07/06/1921 Maryland Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🙀 Yes 2 🗆 No Wicomico Hebron Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21830 USA 209 W. Main St., Apt. 12 and Mental Hygiene. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? 1 ☐ Yes 2 🔀 No If Yes, Give Black, White, etc. ģ 1 Never Married 2 Married 21215-0036 1 Yes 2 No Specify: Specify: 3 X Widowed 4 Divorced Completed white Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) domestic homemaker Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Anna E. Mariner and 2 should be William G. Truitt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1505 Arbutus Dr., Salisbury, MD 21804 Thomas Pusey/son of Health item 27 20b. Place of Disposition (Name of cemetery, crematory or other place)
Wicomico Memorial
Park 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Page 1 a
Department of I
Important: If ite
any injury or ot 1 X Burial 2 Cremation 3 Removal from State 1/5/10 4 ☐ Donation 5 ☐ Other (Specify) Salisbury, MD 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician CORONARY disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner BRIBBROVASCUL Sacusortiethi list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): ending physician and use as the burial-transit requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 - Ectopic pregnancy ō in the past 12 months? 4 Pregnant at time of death 9 Unknown Month Year 5 Other (specify) Dav 1 Yes 2 L 9 Unknown detached s been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 1 Tes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an To the Hospital or Attending Physician: The law page 2 performe After this certificate 1 Yes Division of Vital 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 1 Tes မှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) injury Natural 5 Pending work? 1 ☐ Yes 2 ☐ No death. Accident Investigation the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after de To the Funeral Directo completed filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month. Day, Year) 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) 21802 ettuntu

State Registrar 31. Date filed (Month, Day, Year)

WAR

JAN 0 4 2010

32 Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 9 2010 Glenn Rabin Eller 0742 January A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** E1kton Ceci1 Union Hospital If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours 1 X M 2 □ F Virginia 70 July 26, 1939 231-48-6229 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, its Modified any injury or other traumatic event, its Modified and injury or other traumatic event. 1 ☐ Yes 2 👿 No Director E1kton Maryland Ceci1 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 45 Maple Shade Lane 21921 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 🕅 Married Maryland 21215-0036 1 □Yes 2 🛣 No Specify: Specify: \$ 3 Widowed 4 Divorced White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Construction/ Elementary/Secondary (0-12) College (1-4or 5+) Owner Remodeling 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George Eller Sally Price ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Jessie F. Eller/Wife 45 Maple Shade Lane, Elkton, MD altimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition January 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Union Cemetery 12, 2010 Union, MD 22 Name and Address of Facility Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, ure of Funeral Service Licensee 21921 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 4691 /Medical **Examiner** Sequentially list conditions, if any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last death certificate be executed burial-trans and to (or as a consequence of): Box 68760 attending physician Physician/Medical the use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 4 ☐ Pregnant at time of death 9 ☐ Unknown 1 ☐Yes 2 XNo 5 Other (specify) P.0. signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 MInpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred ie Hospital or Attending Pin 24 hours after death. 27. Manner of Death 28c. Injury at Work? 1 XNatural 2 ☐ Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation filled in by the 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. To the within 2

State Registrar 29b. Signature and title of certifier

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Melchor E. Madarang,

29c. License number

D0059223

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ January 3 Day 2010 John T. Fitzsimmons Sr. 8:00 a^M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Howard 9697 Gwynn Park Drive Ellicott City 5. Social Security Number If Under 1 Year If Under 24 Hrs Funeral 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Hours 215-34-7939 1 🙀 M 2 🗆 F Months 1070871937 **Director** 72 MD Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Ellicott City 1 Tes 2 XNo Howard MD 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 21042 United States 9697 Gwynn Park Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces Black, White, etc. 1 Never Married 2 Married ģ Yes 2 No Maryland 21215-0036 1 ☐ Yes 2 No Specify: White If Yes, Give Specify: 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 n and Mental Hygiene.
7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Electrical Engineer Westinghouse 4 permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Mary O'Brien Bernard Fitzsimmons 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda A. Fitzsimmons - wife 9697 Gwynn Park Drive Ellicott City, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State CrestLawn 01/06/2010 Marriottsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign tu Funeral Service Licensee M01411 22. Name and Address of Facility Harry H. Witzke's Family F.H. Inc. 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part t. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician retartalia cancer 7 MUNIY Medical resulting in death) Due to (or as a consequence Examiner Sequentially list conditions, if any, hearing to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to for all a consectionds of g physician and is the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown jo Month Year Pregnant at time of death 5 Other (specify) been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of page 2 s autopsy 2 2 No 1 Yes 2 No Yes 25. Was case referred to medical director Be 26. Place of Death (Check only one) Hospital: 1 🗆 Yes 2 🗓 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this completed filled in by the funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 💆 Natural 5 Pending iniury work? 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: A Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) Medical 29a. Certifier Gertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 29c. License number 019714

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Mont

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32 Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 00853 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month 1 2010 6:24 A M <u> Laraine Nicole Freund</u> Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard 6120 Fence Post Ct. Columbia 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🔀 F Hours Director 19 217-29-8343 Usual Residence of Decedent 10a. State 10b. County 10d. Inside City Limits or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location within 72 hours after death with the Maryland Director 1 ☐ Yes 2 No Columbia MD Howard 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6120 Fence Post Ct 21044 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. White If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry and Mental Hygiene. is marked other than College (1-4 or 5+) Elementary/Seconday (0-12) Education Student other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ျ Lisa Steiner permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic David Freund 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6120 Fence Post Ct. Columbia, MD 21044 Lisa Freund - mother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Columbia Mem. Park 1/7/2010 Columbia, MD 22. Name and Address of Facility Harry H. Witzke's Family F.H. Inc. 21. Signature of Funeral Son ice Licensee M01411 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ tailure Heart YERIS Medical resulting in death) Due to (or as a consequence of): Examiner ransplant lears Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

The Funeral Director: After this certificate has been signed by the attending physician and To the Funeral Director: After this certificate so should be detached for use as the burial-transit completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) Day Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by ly mphoma 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of death? 1 Yes 2 No Yes 2 -25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 2 No Hospital: Other: 1 Yes ည 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending Investigation injury ☐ Accident ☐ Suicide 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature ar 29c. License numbe 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address o

31. Date filed (Month)

Johns

ause of death (Item 23a) (Type, Print)

Registrar's Signature

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0050595

Hopkins Hospital

600 North Wafe

Baltimore

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) 00854 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** Januarv 2010 3:40A Gerald_ Lee Glass /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Accident Garrett 31575 Garrett Highway If Under If Under 24 Hrs. Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 1 X M 2 □ F /18/1929 Maryland Director 80 216-22-7009 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County d other than "natural", or items 23a or 28a-f show event, the Medical Ever it and the rediffed at 1 ☐ Yes 2 X No Director MD Garrett Accident 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number death with 21520 U.S.A. Funeral 31575 Garrett Highway Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
ant: If Item 27 Is marked other than "natural", or itel Iry or other traumatic event, Itel Medical Evantian 1 ☐Yes 2 ☐ If Yes, Give Year or Dates: 2 **X**No 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo δ Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Masonry contractor 12 Self employed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Kolbfleisch ပ္ Ruth E. Ε. Glass 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 31575 Garrett Hwy., Accident, MD 21520 Department of Health Important: If item 27 any Injury or other to once. L. Grace Glass/ Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Accident, Maryland 1/5/2010 4 Donation 5 Other (Specify) St. Paul's Cem. 22. Name and Address of Facility ${
m Newman}\;$ Funeral Homes 21. Signature of Funeral Service License e 179 Miller St. Grantsville, MD 21536 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Holenocarn /Medical Due to (or as a consequence of): Examiner S uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine siclan and burial-trans Due to (or as a consequence of): attending physiclan for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day 5 Other (specify) 1 ☐Yes 2 ☐ No been signed by the should be detached 9 Unknown 9 Dunknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1 ☐Yes 2 ZNo 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, within 24 hours after death.

To the Funeral Director; After this certificate has completely filled in by the funeral director, page 2 s

> 69 WolfAcre 30. Name and address of

State Registrar

Medical

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

2010

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2136 M Howard, Jr. Charles 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Sallsbury VICONICO If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 9-5-1930 1 X M 2 - F Months Days Hours Maryland 220-26-8273 **Director** 79 Usual Residence of Decedent f Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10b. County 10d. Inside City Limits lld be filed within 72 hours after death with the Maryland Mental Hygiene. Director 1 ☐ Yes 2 🏋 No MD Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 209 Carolyn Avenue 21804 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian. Armed Forces? Black, White, etc. ş 1 Never Married 2 X Married 1 X Yes 2 □ No 1952 Baltimore, Maryland 21215-0036 White 1 Yes 2 No Specify: Specify 3 Widowed 4 Divorced Completed 1953 Year or Dates Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Manufacturer 11 Assembly Worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Charles Howard, Sr. Margaret permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 209 Carolyn Avenue, Salisbury, Maryland 21804 Jacqueline Howard - Wife 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Parsons Cemetery 1-8-2010 Salisbury, Maryland 21. Signature of Funeral Service Lic 22. Name and Address of Facility Bounds Funeral Home 705 E. Main Street, Salisbury, Maryland 21804 23a. Pert 1. Enter the disease, or compositions shock, or heart failure. List only one cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate ne cause on each line Immediate Cause (Final Muce 4 hic Cauley Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner MS (VI) Sequentially list conditions, if any, leading to immediate
Cause (Disease or iinjury Examine Due to (or as a consequence of): attending physician and for use as the burial-transit that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) n signed by the a 1 Yes 2 9 Unknown 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by To the Hospital or Attending Physician: The law requires t within 24 hours after death.

To the Funeral Director: After this certificate has been sign completed filled in by the funeral director, page 2 should be 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Yes 2 No Yes To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Npatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28a. Date of injury (Month, Day, Year) Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work' 1 Tyes 2 🗌 No Investigation 6 Could not be Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d Date signed (Month, Day, Year) 9+1VA 01/03/2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Salisbury md 31. Date filed (Month, Day, Year) 32. Registrar's Signature 4 State JAN 04 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) Day 3 Month 2010 Year \mathbb{A}^{M} 3:40 January <u>Reta Virginia Hiett</u> 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Washington County Village at Robinwood Hagerstown If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) West Virginia Days 1 □ M 2 🛛 F ,1919 11 90 215-20-8225 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1 ☐ Yes 2 No Maryland Washington County Hagerstown 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21740 U.S.A. 1628 Howell Rd. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. 1 □Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Board of Education Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Edith Hendricks Conrad Elbert Conrad 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1628 Howell Rd. Hagerstown, MD 21740 Kenneth P. Hiett-husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 Removal from State 1-6-2010 Hagerstown, Maryland Rest Haven Cemetery 4 Donation 5 Other (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licensee 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SRONDRY Due to (or as a consequence of): Sequentially list conditions, if any cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 5 Other (specify) 2 No 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No (Specify) 27. Manner of Death

Physician /Medical Examiner

attending physician and for use as the burial-transit

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After t al or Attending P s after death.
Il Director: After it in by the funera

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Medical

Physician: The law requires that the death certificate be executed

Box 68760,

P.O.

Division of Vital Records,

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Important: If Item 27 is
any injury or other trau

Physician

/Medical

Examiner

Funeral Director

Completed by

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Funeral

Director

2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examinal near stilled at

Baltimore, Maryland 21215-0036

Pages 1 and 2 should

Examiner Physician/Medical þ funeral director, page 2 should Completed

Be Certification: To

F FEMALE: 23b. Was decedent pregnant in the past 12 months? 9 Unknown

1 Natural

2 Accident

4 - Homicide

3 Suicide

5 Pending investigation

6 ☐ Could not be

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lospita!	1 Inpatient 2	ER/Outpatient	3 🗆 [AOC	Other: 4	Nursing H	ome	5 Residenc	e 6 □Other
28a.	Date of Injury (Month, Day, Year	28b. Time of Injury	М		Injury at Work?			Describe how i	

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2010

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Under the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hagerstown 11110 Medical 32. R gistrar's Signature

D0055994

9H-10 State Registrar

31. Date filed (Month, Day, Year) JAN 06

			State of Maryland / Department / Department /	artment of Hea			giene Reg. No 2010	00857
			Negistrar Decedent's Name (First, Middle, Last)			2. Date of Dea	ath	3. Time of Death
	Physicia		Alan Mark Hutton			Month Jan.	2. 2010	8:12 ^M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Loc	cation of Death		4c. County of Death	
			Union Hospital	E1kton			Ceci1	
	Funeral		5. Social Security Number 6. Sex 7. Age (<i>In yrs. last birthday</i>) 202-48-8423 1 √ M 2 □ F 5.2 Yrs.		Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day	y, Year) Cour	place (State or Foreign ntry)
	Director		202-48-8423			Sept.	10,1957 PA	
	land w		10a. State 10b. County 10c. City, Town or Lo	cation			1	0d. Inside City Limits
	Mary -f sh	tor	MD Cecil Elkton					1 ☐ Yes 2 → No
	r 28a	Director	10e. Street and Number	10f. Zip Code			10g. Citizen of What Cour	ntry?
	23a c		45 Bluefield Drive	21921			USA	
	ems	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispa If Yes, specify Cuban, N	anic Origin? (Spe Mexican, Puerto I	cify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	
36	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f show ent, I'm Mydical Evan, iver, unt be nyiffed at	by Fi	1 Never Married 2 Married 1 Yes 2 No If Yes, Give	1 □Yes 2√2 No S	Specify:		Specify: Whi	te
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nd	e filed al Hygi I other vent, I	Be (17. Father's Name (First, Middle, Last)	18.	3. Mother's Name	(First, Middle,	Maiden Surname)	
yla	Ment Ment arkec	2	Warren Murdoch Hutton				eth Johnson	
a	2 should be fi h and Mentai l 7 Is marked ot raumatic evel		. ' ' ' '				er, City or Town, State, Zip	Code)
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Baltimore,	Pages nent of int: If Ite		1 Burial 2 X Cremation 3 Hemoval from State	osition (Name of matory or other place)	1/5/2		,	
트	permit. Pages Department of Important: If Ii any injury or once.			d Funeral I 2. Name and Address o	and the second s	A.	Rising Sun,	MD
Ba	Dep Imp any onc		R	.T. Foard I	Funeral	Home, 1	P.A.	
			23a. Part 1. Enter the disease, or complications that caused the death. Do not en	LS George Ster the mode of dying, s	St.Chesa such as cardiac o	peake (r respiratory a	City, MD 219	Approximate Interval Between
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	/Medical		disease or condition resulting in death) a. Due to (or as a consequence of):	profound 1	hypoxia	-		
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ord	w require been sig should b	ted	Bleeding from tracheostrmy site			1 🗆 \	Yes 2 Mary No 3 ☐ Pro	bably 4 ☐ Unknown
ec	e law has b je 2 sh	Completed				24a. Was autor	psy prior to co	opsy findings available ompletion of cause of
<u>~</u>	The icate pag						ormed? death? 2 ☑ No 1 ☐ Yes	2 🗆 No
Vital Records,	sician certif rector	Be	25. Was case referred to medical examiner? Hospital:	Others	6. Place of Death			
Division of	Phys r this aral di	1: To	27. Manner of Death 28a. Date of Injury 28b. Time of	IN 3 DOA			dence 6 Other (Speci how injury occurred	f(y)
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N N	Atter er dea ector by the	ifica	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, structure building, etc. (Specify)	reet, factory, office		28f. Location (3	Street and Number or Run	al Route Number,
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	To the Hospital or Attending Physician: The I within 24 brouts after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or in and manner stated.					
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,	Kiin		30. Name and address of person who completed cause of death (Item 23a) (Type,		~ T 0		11 11 2010	
_	2+1VA		Kerry Leuky 106 Bow Street	Elkton	MD 219	21		
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature	,				
	Registr	ar	and a rail Christian a. Banks	,				

DHMH 17 Rev 1/2001

10-00074 Grace Irekpolo Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

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		1- For State Certificate of Death Reg. No.								00000		
Physicia Medical Exami	ın/	1. Decedent's Name (First, Middle,Last) GRACE NKEIRU IREKPOLO							Month Day Year			3. Time of Death 1650 hrs
		4a. Facility Name (if not institution Harford Memorial Hos		4b. City, Town, or Location of Death Havre de Grace								
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Eggs								Foreign		
Director											intry) NIGERIA	
w any		10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits										
ryland	ctor	MARYLAND HARFORD ABERDEEN 10e. Street and Number 10f. Zip Code 10g. Citizen						of What Coun				
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Director									NIGERIA		
eath with items 2 ust be n	uneral	11. Marital Status 1 Never Married 2 X M		Was Decedent Ex Armed Forces?	ver in U.S.		Decedent of Hispa es, specify Cuban, I			14.	. Race - Americ White, etc.	an Indian, Black,
after d	by Fu	3 Widowed 4 Divorced If Yes, Give Year or Dates:				1 Yes 2 X No specify:						BLACK
2 hours	70	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)				 Decedent's Usual Occupation (Give kind of work don- during most of working life. DO NOT use retired) 				16b. Kind of Business/Industry		
0036 within 7 iene. eer than	Complete	4 REGISTERED NUI								ITAL		
215-(e filed very filed other) and, the	To Be Co											
D 21, should be and Men		19a. Informant's Name/Relations SAMUEL IREKPO		-		_	Address (Street			-		
b, ML and 2 s fealth au item 27 traums		20a. Method of Disposition			20b. Place o	f Disposit	ion (Name of ceme		Date		ation - City or 1	, MD 21001 Fown, State
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Medical		1 X Burial 2 Cremation 4 Donation 5 Other S	pecify:	emoval from State		D MEI		ARDS. 0	1/14/10	ABF	ERDEEN,	MARYLAND
Balti permit. Departr Import injury		21. Signature of Funeral Service Licensee 22. Name and Address of Facility LISA SCOTT FUNERAL HOME. P.A.										VED 21070
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and										
Wedital Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Po	eripartu o (or as a consequ		nary	artery d	issection	on			Death
		Sequentially list conditions,	b									
	edical Examiner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated										
uted nd ransit		events resulting in death) Last Due to (or as a consequence of): d.										
760, icate be executed physician and the burial - transit		XUNPENDED AMENDED 23a,27, permE, g901 3/15/10 TT										
18760, rifficate being physic as the bur	an/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	-	. If yes, outcome Live birth	2	Feta	al death 3	Ectopic pregna	ncy		ate of delivery onth D	ay Year
Box 687 e death certifi	ysician/		known 9	Pregnant at tin	ne of death	Oth	er (Specify)					
tal Records, P.O. Bo cian: The law requires that the de certificate has been signed by the rector, page 2 should be detached?	by Phy											
ds, P						1 24a			24a. Was a			
COF	Completed	·							autops perfori 1 ✓ Yes 2	ned?	prior to co death? 1 🗸 Yes	ompletion of cause of
al R	0	25. Was case referred to medica examiner?	<u> </u>					of Death (Check of				
of Vit Physic er this c	ToB	1 ✓ Yes 2 No 27. Manner of Death	Hospita	8a Date of Injury	2 🗸 ER/O	utpatient Fime of In			g Home 5 F	Residence		
on of ending Pl ath. or: After the funeral	tion:	1 X Natural 5 Pen	ding	(Month, Day,Year	n)			es 2 No	204. 000020	o ii ii gai y		
Division of Vital Records, P.O. ral or attending Physician: The law requires that the starter death. "al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. 2i							28f. Location (Street and Number or Rural Route Number, City or Town, State)			
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical Ce	29a. Certifier (Check only one) Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated one) Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)										
To COI	Me								th, Day, Year)			
		30. Name and address of person who completed cause of death (Item 23a)						January 4, 2010				
1		30. Name and address of persor Russell Alexander MI		eted cause of dea stant Medical		1111	Penn Street, E	Baltimore, MI	D 21201			
St Regist	ate rar	31. Date filed (Month, Day, Year)	10 h	32. Registrar's	Signature	de		004-1				
	_								-			

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 0000 hrs **Medical Examiner** Ahymyree Katryice Contessa Kynlynn January 10, 2010 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death Washington County Hospital Hagerstown Washington 9. Birthplace (State or Foreign Maryland Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYY) **Funeral** Hours 219-85-5998 Director 2XF 2009 Oct. 1 M 1. Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a State 10b. County permit Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other than "naturo" injury or other traumatic event. And Maryland Washington County Hagerstown 1 X Yes 2 No or 28a-f show Directo 10e. Street and Number 10g. Citizen of What Country? 1013 C Noland Dr. 21740 U.S.A. Funeral Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, Armed Forces? White, etc. 1 X Never Married 2 2 X No Yes Black 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify. þ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) N/AN/A 0 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) Be Cyrea Katryice Kynlynn Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ပ 1013 C Noland Dr. Hagerstown, MD 21740 Cvrea Kvnlvnn-mother 20a. Method of Disposition 20b, Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Date crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 1-15-2010 Smithsburg Crematory Smithsburg, Maryland 4 Donation 5 Other Specify 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd. North Hagerstown, 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician failure. List only one cause on each line Between Onset and Medical Death a Sudden infant death syndrome (SIDS) Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last his certificate has been signed by the attending physician and director, page 2 should be detached for use as the burial - transi The law requires that the death certificate be executed sician/Medical ▼ UNPENDED **AMENDED** 23a,27,permE, g902 4/6/10 TT Division of Vital Records, P.O. Box 68760, IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth Fetal death 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 V No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of performed? death? Yes 2 No this certificate 1 🗸 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifi 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 ✓ ER/Outpatient 3 Other Nursing Home 5 Residence 6 Other DOA 2 No 1 🗸 Yes 2 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 X Natural 5 Pending 1 Yes 2 No filled in by the 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f, Location (Street and Number or Rural Route Number, City 3 6 Could not be determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) O.C.M.E. January 11, 2010 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Zabiullah Ali, M.D. 32. Refistrar's Signature 31 Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 9 Mildred Ilean Lashbaugh 2010 1:55 A Jan /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 10625 New Hope Rd NW Frostburg Allegany 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 15 1926 Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday, **Funeral** Months 1 □ M 2 🗷 F Days Hours 215-20-7232 83 Maryland Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits al Hygiene, I other than "natural", or items 23a or 28a-f show went, the Medical Examinat roust be notified at 1 ☐ Yes 2 No **Funeral Director** MD Allegany Frostburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10625 New Hope Rd NW U.S.A. 21532 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: Specify: Completed by Specify: 3 ₩Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 Homemaker own home 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any linity or other traumatic event once. 17. Father's Name (First, Middle, Last) Be George Phillips Clara May Clise Phillips ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 192 Avilton Rd Lonaconing, MD 21539 Janice Wyatt daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rocky Gap Veterans 1-11-2010 Flintstone, MD 22. Name and Address of Facility Sowers Funeral Home, P.A. 21. Signature of Funeral Service Licensee Man Jow ex 60 W. Main St., Frostburg, MD 21532 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one caus an each line. Immediate Cause (Final gotherien Syns **Physician** disease or condition resulting in death) /Medical Due to (or a consequence of): Examiner Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). sician and burial-transit law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death
☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Year Month 5 Other (specify) Division of Vital Records, P.O. s been signed by the s should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of page 2 s autopsy performed death? certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 🗷 No e Hospital or Attending Physician: 124 hours after death. e Funeral Director: After this certifica letely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner eath 28b. Time of 28a. Date of injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the Hosp within 24 hou To the Funer completely fil Medical

State Registrar

29b. Signature and title of

30 Name and address of person who comple

DHMH 17 Rev 1/2001

ed cause of death (Item 23a) (Type, Print)

State

Registrar

32. Registrar's Signature

SERVA.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 1 - For State Registrar 00862 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Francis Thomas Mowbray 2010 January 4, 6:35 A 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Egle Nursing & Rehab Center Lonaconing Allegany | Trunder 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Pay, 1) | Nin. | Aug. | 17, 5. Social Security Number 7. Age (In vrs. last birthday) 1 M 2 ☐ F Aug. 213-24-7003 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a, State 1 ☐ Yes 2 XNo Barton Allegany 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 24021 Dalmation Drive 21521 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 DYes 2 No If Yes, Give Year or Dates: Korean 1 ☐ Never Married 2 ☑ Married specify: white 1 ☐Yes 2 No Specify. 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Paper Manufacturer Papermaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Thomas Mowbray Marie Footen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Peggy Mowbray/ wife 24021 Dalmation Drive, Barton, Maryland 21521 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Barton Maryland Laurel Hill Cemetery 4 Donation 5 Other (Specify) 2010 22. Name and Address of Facility Boal Funeral Home 21. Signature of Funeral Service Licenses 02 111 Church St, Westernport, Maryland 21562 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CEREBROVASCULAR Due to (or as a consequence of): Sequentially list conditions, if any, leading to influed at cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a nonsequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant Pregnant at time of death 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 \(\text{Yes} \) 2 \(\text{N} \) No

Physician /Medical Examiner

and

permit. Pages 1 and 2 Department of Health Important: If Item 27 any injury or other tra

Physician

/Medical

Examiner

Funeral

Director

?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Examiner must be notified at

Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene.
Int: If Item 27 is marked other than "natural", or ite

Baltimore, Maryland 21215-0036

Funeral Director

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Completed

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Examine

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P.O. Box 68760,

Records,

Division of Vital

the Hospital or Attending Physician:

burial-trar ned by the attending physician detached for use as the buria Physician/Medical cale has been signed by page 2 should be detacl <u>۾</u> Completed within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, t Be Medical Certification: To

IF FEMALE:
23b. Was decedent pregnant
in the past 12 months?
1 □ Yes 2 No

25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA

27. Manner of Death Natural 2 Accident 3 Suicide

5 Pending investigation 6 Could not be

28a. Date of Injury (Month, Day, Year) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

and manner stated.

28b. Time of Injury 28c. Injury at Work?

28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29b. Signature and title of certifier

4 Homicide

29a Certifier

29c. License number D26907 29d. Date signed (Month, Day, Year)

042010

Hellon 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

21502 Dr. Harjit Sidhu, 925 Bishop Walsh Drive, Cumberland, MD

State Registrar

5

31. Date filed (Month, Day, Year) JAN-4



State of Maryland / Department of Health and Mental Hygiene Reg. No. 2010 1 - For State Registrar 00863 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) $\overset{\mathsf{Day}}{2}$ **Physician** 2010 10:40 Virginia Harrill Plummer January /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Village at Robinwood Washington County Hagerstown 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min. Days 1□M 2X F Months Hours 237-24-0558 Director 87 June 14.1922 North Carolina Usual Residence of Decedent the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State ral", or Items 23a or 28a-f show Examiner must be notified at 1 ☐ Yes 2 XNo Director Maryland Washington County Hagerstown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If them 27 is marked other than "nearly light or other traumating once. 18719 Dover Dr. 21742 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 🛣 No Specify ģ Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Vice President Advertising Company 4 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, Be Robert Lee Harrill Vera Michael Harrill ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Phoebe Black-daughter 5921 Holland Rd. Rockville, MD 20851 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Smithsburg Crematory 1-4-2010 Smithsburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Douglas A. Fiery Funeral Home 21. Signature of Funeral Service Licensee 1331 Eastern Blvd. North Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ONANY disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death, the Funeral Director: After this certificate has been signed by the attending physician and mpletely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 Z No Month Year Day 4 Pregnant at time of death 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 No 2 Accident 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 24 hor To the Fune completely f and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VOH-10 Campus Rd suite Higginbotha 11110 medi 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 06 Registrar

P.O. Box 68760.

Division of Vital Records,

	_ FOI	Indelible Ink. Ensure Alepartment of Health and M	
		Certificate of Death	Reg. No. 2 3. Time of Beath
Physician /Medical Examiner	Carlos Lee Powell 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	January 3, 2010 1:05 p. M
Funeral Director	Garrett County Memorial Hospital 5. Social Security Number 232-62-5809 General Hospital 7. Age (In yrs. last birth 69	Months Days Hours Min	Garrett 8. Date of Birth (Month, Day, Year) Jan. 12, 1940 Garrett 9. Birthplace (State or Foreign Country) West Virginia
Maryland a-f show ifled at	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town of Carrett MD Garrett Oaklan		10d. Inside City Limits 1 ☐ Yes 2 🌠 No
n with the Mar 3a or 28a-f sl st be notified	10e. Street and Number 7231 Garrett Highway	10f. Zip Code 21550	10g. Citizen of What Country? United States
DESILITIOTE, IMETYIBITION Z I Z I 3-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 12. Yes 2 No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ₩ No Specify:	
Completed by F	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	Decedent's Usual Occupation Give kind of work done during most of work life. DO NOT use retired) ruck Driver	16b. Kind of Business/Industry
Marytand Z nd 2 should be filed lith and Mental Hygi 27 is marked other r traumatic event, it	17. Father's Name (First, Middle, Last) Carlos Ray Powell	18. Mother's Name	e (First, Middle, Maiden Surname) Le Reel
6, IMar 1 and 2 sho Health and em 27 Is m ther traum	Lenora Powell, Wife 73	231 Garrett Highway,	al Route Number, City or Town, State, Zip Code) Oakland, MD 21550 Date 20c. Location - City or Town, State
altimore, mit. Pages 1 ar apartment of Hea portant: If Item. y Injury or other ice.	1 🛣 Burial 2 □ Cremation 3 □ Removal from State cemetery,	crematory or other place) r Union Cemetery 1/6	5/2010 Gortner, MD
B and be a	23a. Part. Enter the disease, or complications that called the death. Do no shock, or heart failure. List only one cause on each line.	21 N. Second St.,	Funeral Home, P.A. Oakland, MD 21550 or respiratory arrest, Approximate Interval Between
Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death) a. Atheroscience of Due to (or as a consequence of	hi Cardiovascula	onset and Death 17 yas
<u>ē</u>	Sequentially list conditions, if any, leading to him ediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of Due to (or as a consequen		
that the death certificate be eved by the attending physician cetached for use as the burian Physician/Medical E	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown d. 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	23d. Date of delivery Month Day Year
w requires tha been signed I should be get	Part II. Other significant conditions contributing to death but not resulting in the Hypertension Diabetes mellitus	he underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 SaYes 2 No 3 Probably 4 □Unknown
stcian: The law requires to certificate has been signer rector, page 2 should be on the completed by			24a. Was an autopsy performed? 1 ☐ Yes 2 No 2 1 ☐ Yes 2 No 2 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
ding Phys	25. Was case referred to medical examiner? 1	atient 3 DOA Other: 4 Nursing Home of Work? M 1 Yes 2 No	h (Check only one) ome 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)
To the Hospital or Attenwithin 24 hours after death for the Funeral Director: completely filled in by the Medical Certifical	29a. Certifier (Check only one) Medical Examiner: On the basis of examination and/end many stated.	death occurred at the time, date and place, or investigation, in my opinion, death occur	and due to the cause(s) and manner as stated. red at the time, date and place, and due to the cause(s)
To the Hos within 24 hr To the Fun completely	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
7+1/4	30. Name and address of person who completed cause of death (Item 23a) (True 1) (Tru	ype, Print) 027 MEMORIAL	DRIM OAKLAND MD 2/5.
State Registrar DHMH 17 Rev 1/2001	JAN - 5 2010 > Janua A	g. para	

			For State	State of Marylan						7 1 1 1	00865
			Registrar		Cei	rtificate of L	Jeath ————————————————————————————————————	2. Date of Dea	teg. Note	_010	3. Time of Death
	Physici	an	Decedent's Name (First, Middle, Last)					Month	Day		
and.	/Medic		4a. Facility Name (If not institution, give	Ann Lewis Pia	ızza	4b. City. Town, or	Location of Death	January		2010 County of Death	UZZ3 A
	Examin	er	Union Hospital	,		E1kton				Cecil	
	Funeral		5. Social Security Number 6. Se		last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	Year)		place (State or Foreign
	Director		234-24-0362	^{3 M 2} ₩ F 87	Yrs.	IVIOTIUIS Days	Tiodis Willia	May 18,	192		Virginia
	and		Usual Residence of Decedent 10a. State 10b. County	10c. Cit	y, Town or Lo	cation					10d. Inside City Limits
	Maryli f sho	jo	Ma1	1	Elkton						1 X Yes 2 □ No
	the 7	Director	Maryland Cecil 10e. Street and Number		SIKCOII	10f. Zip Code			10g. Citi:	zen of What Cou	ntry?
	3a ol		502 Skipjack Cour	t		21921			Ur	nited St	ates
	72 hours after death with the Maryland 'natural', or items 23a or 28a-f show don! Evan the notified at	Funeral	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13.	Was Decedent of H	ispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No-		14. Race - Ameri Black, White,	
98	after or ite		1 Never Married 2 Married	1 □Yes 2 💢 No If Yes, Give		1 ∐Yes 2 🕅 No	Specify:	,		Specify:	
Ö	hours ural"	od by	3 X Widowed 4 □ Divorced	Year or Dates:	16a Dece	dent's Usual Occup	ation		16h Kii	Wh:	
21215-0036	in 72 n "nai	Completed	15. Decedent's Edu (Specify only highest grad	e completed)	(Give	kind of work done of DO NOT use retired	durina most of work	ting			,
212	filed within Hygiene. other than "	E O	Elementary/Secondary (0-12) 12	College (1-4or 5+)	Of	fice Assi	stant		I	Retail_	
pu	e filed al Hy I othe vent,	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Nam-	e (First, Middle,	Maiden	Surname)	
<u>ya</u>	2 should be fi and Mental H is marked ot aumatic ever	2	Homer Curry		1		Edith K				
Maryland	2 sho and is m raum		19a. Informant's Name/Relationship (T)	•			and Number or Rui				p Code)
	1 and 2 Health tem 27 i	_	Robert A. Piazza/ 20a. Method of Disposition				Drive,	Date	MD 20c. Lo	21921 ecation - City or T	own, State
Baltimore,	8 = 0		1 ☐ Burial 2 🖾 Cremation 3 🗆 I	removal from State		sition (Name of matory or other place		ary 9,		•	
Ē	permit. Page Department of Important: if any injury or once.		4 ☐ Donation 5 ☐ Other (Specify, 21. Signature of Funeral Service Licens			IS & Co., I		l.		Vest Che	ster, PA
Ba	permi Depar Impo any ir		Donald &	Harbi	H:	icks Home 03 W. Sto	ss of Facility for Fune ckton Str	erals, P ceet. El	.A. ktor	n. MD 2	1921
	1 1 1		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only o	lications that caused the deat							Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	· CEREBRO	VASCI	ILAYL A	CADEMT	F			Onset and Death
	/Medical		resulting in death)	Due to (or as a conseq	uence of):						
	Examiner	<u>.</u>	Eaquentially list conditions,	Due to (or as a conseq	y Are	TERY D	SEASE				
	ted	Examiner	E aquer trailly not conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			Labile	DENIA	rAllu	DE		
	execu and al-trar	xar	that initiated events resulting in death) Last	c. ACUTE Due to (or as a conseq	uence of):	TICOMIC	Jee 1911C	PAILO	Jec		
58760,	icate be executed physician and the burial-transit	dical		d. DEMENT							
_	rtificat ng phy as th	ledi									
Вох	The law requires that the death certific ate has been signed by the attending page 2 should be detached for use as	Physician/Me	23b. was decedent pregnant	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta		☐ Ectopic pregnanc	:y		1	23d. Date of deli-	very Day Year
O. E	at the dea by the at tached fo	sici	in the past 12 months? 1 □ Yes 2 🖼 No 9 □ Unknown	4 ☐ Pregnant at time of o	death 5	Other (specify)				WORTH	Day Tear
σ.	that the ned by detacl		Part II, Other significant conditions co	intributing to death but not res	ulting in the u	nderlying cause giv	en in Part I.	23e. Did to	obacco L	use contribute to	the cause of death?
Records,	signe d be	d by		3	Ŭ	, , ,		1 🗆 \	es 2	□ No 3 □ Pro	bably 4 🗷 Unknown
9	v requii been s should	Completed						24a. Was	an	24b. Were aut	opsy findings available
Re	The law cate has page 2 :	шć			_				rmed?	death?	ompletion of cause of 2 □ No
Vital	sician; The certificate rector, pag	Be C	25. Was case referred to medical				26. Place of Dea		2 No ne)	1 ☐ Yes	2 🗆 NO
Į	di is	To B	examiner? 1 ☐ Yes 2 No	Hospital: 1 Anpatient 2	ER/Outpatie	nt 3 DOA Oth	er: 4 Nursing H	ome 5 ☐ Resid	dence	6 ☐ Other (Spec	eify)
n of	ding Ph h. Affer th funeral	ü	27. Manner of Death 1 ★Natural 5 □ Pending	28a. Date of Injury (Month, Day, Year)	28b. Time o Injury	Wor		28d. Describe h	now injur	ry occurred	
Sio	Attending or death. ector: After by the funer	cati	2 Accident investigation 3 Suicide 6 Could not be				lYes 2 □No	00/ 1			
Division	I or Attendi after death. Director: A I in by the fu	Certification:	4 Homicide determined	28e. Place of Injury - At he building, etc. (Special	ome, tarm, sti fy)	reet, factory, office		City or Tov			ral Route Number,
	Hospital		29a. Certifier 1 Certifying Ph	/sician: To the best of my kno	owledge, dea	th occurred at the ti	me, date and place	e, and due to the	cause(s	and manner as	stated.
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical	(Check only 2 Medical Exam	iner: On the basis of examination and manner stated.	ation and/or in	nvestigation, in my	opinion, death occu	rred at the time,	date and	d place, and due	to the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifier			29c. Licens	se number		29d. Da	ite signed (Month	n, Day, Year)
			400	m. D		D6	9181		1	18/20	010
			30. Name and address of person who o	ompleted cause of death (Iter	m 23a) (Type,	Print)					
			TAMMAY SAMAIN 31. Date filed (Month, Day, Year)	32 Revistrar's Signa	STILE!	=7, ELK	TON, N	1D2192	1		
	Sta Regist		JAN 15	2010 Leneur	1	based					
			Aless a s		1 16						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 For State Registrar 00866 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ :5/A M Robbins J. Elizabeth Medical Facility Name (if not institution, give street and number, 4c. County of Death or Location of Death Examiner 0 NICOMICO 8. Date of Birth (Month, Day, Year) 10-14-1928 birthday) If Under 1 Year If Under g. Birthplace (State or Foreign Funeral 7. Age (In yrs. las: 1 □ M 2 🏻 F Months Days Hours Min Country) Maryland Yrs. Director 81 Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at **Funeral Director** 1 X Yes 2 □ No MD Ocean City Worcester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a 21842 522 Nautical Lane USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. 5 Completed by 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examin ☐ Yes 2 🗓 No If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Baltimore, Maryland 21215-0036 White Specify. 3 X Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Baltimore County School 11 Cafeteria Worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ William Burgess Wilhemina Voight 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maryland 21229 Emory M. Whitney, Jr. - Son 718 Stamford Road, Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State cemetery, crematory or other place, of Delmarva 1-4-2010 4 Donation 5 Other (Specify) Creamtory Delmar, Delaware 21. Signature of Fureral Service Licensee 22. Name and Address of Facility Bounds Funeral Home 705 E. Main Street, Salisbury, Maryland 21804 23a. Part 1. Enter the disease, or complic shock, or heart failure. List only one ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final DRMRNTIA Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner DISEASR STACLE Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Date to for es a eurosagaenes of: use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury and that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 No
9 ☐ Unknown Day Pregnant at time of death should be detached 9 Unknown signed by Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by No No 3 Probably 4 Unknown peen Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy page 2 this certificate 1 Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 1 🗌 Yes HOSPICE ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 27. Magner of Death 28a. Date of injury 28b. Time of Certificate: 28c, Injury at 28d. Describe how injury occurred (Month, Day, Year) injury 🖒 Naturai 5 Pending death. 1 Yes 2 No Accident Investigation after death the 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. completed filled in by determined City or Town, State) 24 hours a Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the I within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day. Year) 10058410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

GHUNTIN

31. Date filed (Month, Day, Year)

21202

BOP

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 2010 For State Registrar 00867 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death JANUARY **Physician** 2010 Annabelle Emmert Roulette 6:55A.M. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Reeder's Memorial Home Washington Boonsboro 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🗓 F Months Days Hours 213-18-8738 88 Director 26, 1921 Pennsylvania Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State 10d. Inside City Limits 10b. County 28a-f show injury or other traumatic event, the Wedlant Examiner a ust be notified at 1 ☐ Yes 2 X No Funeral Director Maryland Washington Sharpsburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a or 21782 17511 Shepherdstown Pike USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 X No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🛛 No Specify Completed by Specify: White 3 X Widowed 4 ☐ Divorced "natural" 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) filed within 7 I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Housewife Home 9 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be should be fi and Mental I Clarence Gordon Emmert Anna Alice Stephey ပ is mg 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If Item 27 is any injury or other tra Pages 1 and 2 Suzanne R. Nalley - Daughter 17507 Shepherdstown Pike Sharpsburg, MD 21782 20a. Method of Disposition 20c. Location - City or Town, State Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt. View Cemetery 01-08-2010 Sharpsburg, Maryland ^{22. Name and Address of Facility} Osborne Funeral Home, P.A. 425 S.Conococheague St. Williamsport, MD 21. Signature of Funeration Williamsport, MD 21795 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final (MPARLYTON **Physician** MYOCORDIAL 10-15 mag disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ARRYTHMIAS 10-15 min Sequentially list conditions Examiner any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending PhysIclan: The law requires that the death certificate be executed morny Cornemy attending physician and burial-trar Due to (or as a consequence of) YEGAR. Physician/Medical IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 1 □Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 MNo Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after deatl Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) within 2. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 1 Order 010 616 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5H-5 GHAZALA OADIR, 20311 LAPPANS ROAD, BOONSBORO, MARYLAND 21713 301-432-8470 31. Date filed (Month, Day, State JAN 06 Registrar

ANNABELL

Maryland 2121

Baltimore,

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** A M 2010 1020 Julie Ann Roark January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Ceci1 Union Hospital E1kton If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours Months Days Min. 1 □ M 2 💢 F Yrs April 22, 1966 Director 43 Delaware <u>215-80-1486</u> Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, it is Modical Exp. 1.11 in the motified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 🕅 No Directo Maryland Cecil Elkton 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 12 Rock Creek Drive 21921 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 📉 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ∐Yes 2 🛣 No If Yes, Give Year or Dates: Specify þ Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Member Services Automobile Assistance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Daniel Lee Roark Marion Maytas 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Danielle N. Grimsley/Daughter 3 Four Seasons Parkway, Apt. 5, Newark, DE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition January 1 🕅 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Union Cemetery 12, 2010 Union, MD 21. Sign ture of Funeral Service Licensee 22. Name and Address of Facility Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton 21921 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** SALLONG /Medical Due to (or s a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed ardna attending physician and for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4 Pregnant at time of death 5 Other (specify) the 9 Unknown 9 🗆 Unknown ģ cate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 ☐ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ٩ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Certification: 5 Pending investigation 1 Natural 1 ☐Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. within 2. 29b. Signature and title of certifier 29c. License number 29d. Date/signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day,

bins

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 7:18 A M 2010 January 4, /Medical Paul Eugene Spear 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Grantsville Garrett Goodwill Mennonite Home Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex Social Security Number **Funeral** 1**⋉**M 2□F Months Days Hours March 21, 1936 Maryland Director 220-32-3967 Usual Residence of Decedent 73 10c. City, Town or Location Maryland 10d. Inside City Limits 10a, State 10b. County a or 28a-f show t be notified at show 1 ☐Yes 2K No Director Friendsville MD Garrett 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. ral", or items 23a Examiner must b 21531 USA 8753 Friendsville Rd. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 XNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 M Married Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 X No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced er than "natur, the Medical E 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 Maintenance Gas Transmissions 7 Is marked other traumatic event, t 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Izetta Savage ၉ John Spear 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21531 8753 Friendsville Rd., Friendsville, MD Item 27 I Alice M. Spear/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Important: If It any injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Jan. 7, 2010 Friendsville, MD Steele Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Newman Funeral Homes, P.A. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee P.O. Box 275, Grantsville, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Approximate nterval Betw Onset and Death Immediate Cause (Final **Physician** neum resulting in death) /Medical to (or as a consequence of): Examiner Deratz Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner physician and the burial-transit Due to (cras a consequence of): Physician/Medical attending pl 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 ♣ No 24a. Was an autopsy perform

Hospital or Attending Physician; The law requires that the death certificate be executed Box 68760 Division or Vital Records, P.O. this certificate After 1 in 24 hours after were the Funeral Director: Af within 2 To the the

Be

Certification: To

Medical

25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Hospital: 1 Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0034231 January 4, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 124 Miller St., Grantsville, MD

State Registrar

Robin Bissell, 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 3: 5 er ay Medical 4a. Facility Name (if not institution, give street and nu 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospital Takoma Park Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 □ M 2 🖾 F Months Days Hours Min. (Month, Day, Yearnuary 23, Washington, 218-20-0802 91 Director January Usual Residence of Decedent If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importants if them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he matified at 10a, State 10c. City, Town or Location 10d, Inside City Limits Director 1 X Yes 2 No Maryland Prince George's Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20782 5805 Queens Chapel Road USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Bace - American Indian. Armed Forces? 1 ☐ Yes 2 🔀 No Black, White, etc Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: White 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ William Franke Nellie Dyer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William L. Sullivan / Son 22 Ridge Road, Apt. #324, Greenbelt, MD 20770 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 1/7/2010 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemetery . Signature of Funeral Service Licensee 22. Name and Address of Facility 4739 Baltimore Avenue Hyattsville, MD 20781 Gasch's Funeral Home, P.A. RAY ROSNS 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each hie. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) neumonis Medical Due to (or as a consequence of): Examine Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 - Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Month Dav Year 5 Other (specify) 1 L Yes 2 q | Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
 1 □ Yes 2 □ No 24a. Was an autopsy Yes 2 No æ 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 🛣 No Other: 은 1 M Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 \square Pending X Natural injury 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 🛮 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check

State Registrar only one)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CALLAN

LOX

Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D45660

Bowle MD20)11

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 1 Physician Month 2010 1:35 A M Charles Kenneth Smith January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Lorien Nursing & Rehab Center Carroll Taneytown If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 M 2 □ F 9/9/1918 Director Maryland 217-03-5346 Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mential Hygiene. em 27 is marked other than "natural": or items 239 or 28a-f show r 28a-f show notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 XYes 2 No Director Carroll MD Taneytown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a or 100 Antrim Blvd. 21787 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates WW II 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: þ Specify:White 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 1 2 College (1-4or 5+) Owner/Operator Automobile Agency .. Pages 1 and 2 should be filed w tment of Health and Mental Hygie tant: If item 27 is marked other t ijury or other traumatic event, th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ LeRoy Smith Helen Smith 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 80526 Donna Christine Smith - Daughter 3516 Silver Trails Dr. Ft. Collins, Co 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1/3/2010 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State permit. Page Department of Important: If any Injury or Winfield, MD 4 ☐ Donation 5 ☐ Other (Specify) South Carroll Crematory 21. Signature of Funeral Service Licepse 22. Name and Address of Facility
Myers-Durboraw Funeral Home 136 E. Baltimore St. Taneytown, MD 21787 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner to (or as a consequence of) burial-tran and Due to (or as a consequence of): physician Physician/Medical the IF FEMALE: for use If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1☐ Yes 2☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) the detached 9□Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes ≱ No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performe 1∐ Yes 2 No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 Accident 5 Pending investigation Injury 2 □ No

Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, Hospital or Attending

Maryland 21215-0036

Baltimore,

24 hours after death e Funeral Director: within 2 2 WJZ 5+ IVA State Registrar

this

After t

filled in by

6 ☐ Could not be determined

JAN 04

3 ☐ Suicide

29a. Certifier (Check only one)

4 ☐ Homicide

29b. Signature and title of certifier

31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

and manner stated.

and address of person who completed cause of death (Item 23a) (Type, Print)

1 ☐ Yes

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No LU Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** 915AM Leondine Lucielle Saponara nuam 08,2010 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c County of Death **Examiner** Washington Fahrney-Keedy Memorial Home Boonsboro If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 6. Sex **Funeral** Year) Months 97 1 □ M 2 🖫 F 206-09-0314 28, 1912 Pennsylvania Director Aug. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or items 23a or 28a-f show the Medical Experiment be notified at 10a. State 10b. County 1 □Yes 2 No Williamsport Director Washington Md. 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number 21795 16515 Speilman RD. U.S.A Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 □Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ∐Yes 2 ☑ No Specify: White Specify: þ Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "na any injury or other traumatic event, If a Maricone. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Phillip M. Pepe Marie Iuliano 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Michael Saponara (Son) 16515 Speilman Rd. Williamsport, Md. 21795 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Jan. 14, 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Cville, Pa. 4 ☐ Donation 5 ☐ Other (Specify) St. Rita's Cemetery 2010 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MO1414 12525 Bradbury Ave. J.L. Davis Funeral Home Smithsburg, Md. 21783 00 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** schentiz disease or condition resulting in death) aArlenis /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? oblinche 1 ☐ Yes 2 ☐ No 1 □ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 ™No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification; To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending Investigation 1 ☐ Yes 2 🗆 No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

P.O. | Records, Vital ð Division

requires that the death certificate be executed attending physician and for use as the burial-trar ed by the a ign be page 2 should The or Attending Physician: funeral director, After this 24 hours after death. Funeral Director: A filled in by Hospital completely within 24

filed within 72 hours after death

Baltimore, Maryland 21215-0036

State Registrar

DHMH 17 Rev 1/2001

Medical

ASANT 31. Date filed (Month, Day,

72CT

MO

29c. License number D0018019

1 Lertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year) 2010

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

340 MILLST. HALERSTOWN Mb 21740 MD

32. Regierar's Signature

(Check only one)

29b. Signature and title of certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

initially obtained		1- For State Registrar	Certificate of D		, ,	2010	0087
Physicia Medical Examir	n/	Decedent's Name (First, Middle,Last)	Souls	by	2. Date of Death Month January 8,	1	3. Time of Death 2116 hrs
		4a. Facility Name (if not institution, give street and number) 333 Virginia Avenue Apt. 2		City, Town, or Location of Cumberland	of Death	4c. County of Death Allegany	
Funeral Director		579-19-7427 1XM 2FF 2		If Under 1 Year If Under Months Days Hours		/ 1987 Solution (MM/DD/YYYY) 9. Birth / 1987 Cou	hplace (State or Michigan untry)
death with the Maryland or items 23a or 28a-f show any must be notified at once.	eral Director	MD Allegany 10e. Street and Number 333 Virginia Avenue, Apt 2	2 rin U.S. 13. Was D	0f. Zip Code 21502 eccedent of Hispanic Orig	gin? (Specify Yes or No-	g. Citizen of What Coun USA	
2 hours after "natural", I Examiner	eted by Funeral	1 Never Married 2 Married Armed Forces? 1 X yes 2 1 3 Widowed 4 X Divorced If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade complete Elementary/Secondary (0-12) College (1-4 or 5+)	No 1 Ye	specify Cuban, Mexican $es 2X$ No specify: Usual Occupation (Give of working life. DO NOT	kind of work done	White, etc. Specify: W	Thite Idustry
21215-0036 uld be filed within 72 hours after Mental Hygieue. marked other than "natural", e event, the Medical Examiner	Be Completed	12 17. Father's Name (First, Middle, Last) James Christian	Soulsby	Bon		enee	Ranker
F F F F	<u>1</u>	1 Duriel 2 X Commeties 2 Demonstrate One		le Street,	Cumberland, Date 01/13/2010	MD 21502 20c. Location - City or T	Town, State
Baltimore, permit. Pages I an Department of He Important: If ite injury or other tr		21. Signature of Funeral Service Licensee	22. Namo 40	e and Address of Facility 4 Decatur S	Adams Fami treet, Cumb	erland, MD	•
Physician Medical Examiner		23a. Part 7. Enter the disease, of complications that caused the displace List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if dry, leading to immediate cause. Enter Underlying Cause.	hythmia nce of): diomegaly w			8	Approximate Interval Between Onset and Death
'60, sate be execui physician and he burial - tra		Due to (or as a consequent d	ine a-b, 27 pregnancy 2 Fetal d		99 1/28/10 1	TT 23d. Date of delivery Month Da	ay Year
Cords, P.O. Belaw requires that the determines been signed by the	Completed by Phy	Part II. Other significant conditions contributing to death but r	not resulting in the unde	rlying cause given in Par	23e. Did tob 1 Yes 24a. Was an autopsy perform	24b. Were auto	ne cause of death? ably 4 Unknown opsy findings available impletion of cause of
ion of Vital Rectending Physician: The I seath for: After this certificate I the funeral director, page	To Be	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	ER/Outpatient 3 28b. Time of Injury		Nursing Home 5 Rec? 28d. Describe ho	esidence 6 🗸 Other:	
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical Certification:	3 Suicide 6 Could not be determined (Specify) 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination		at the time, date and place	or Town, Sta	s) and manner as stated	
To vitin To Cor		and manner stated. 29b. Signature and title of certifier When the signature and title of certifier 30. Name and address of person who completed cause of death (I Carol Allan, MD Assistant Medical Examiner	,	29c. License number O.C.M.E.		29d. Date signed <i>(Monti</i> January 9, 2010	h, Day, Year)
Sta Registr	-	31. Date filed (Month, Day, Year) 32. Registrar's Signary 15 2010		S. Daidinore, IVID			
DHMH 17 Rev 1/200)1	00015	ORIGINAL				

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death January 1, 2010 Physician Tak Kwok Tonq 12:04 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Casey House Rockville Montgomery Social Security Number 578–94–2964 If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Oct 3, 6. Sex Funeral 9. Birthplace (State or Foreign Days 1 QM 2 □ F 53 Director Hong Kong Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Examiner must be notified at Maryland Director Montgomery Silver Spring 1 ☐ Yes 2 🔀 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with ment of Health and Mental Hygiene. But it file 27 is marked other than "natural", or items 23a or usy or other traumatic event, it is not other traumatic event, it is not other traumatic event, it is not other traumatic event, it is not other traumatic event, it is not other traumatic event, it is not other traumatic event, it is not other traumatic event, it is not other traumatic event, it is not other traumatic event, it is not other traumatic event. 1516 December Drive #203 20904 Hong Kong Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc 1 ☐Yes 2√∑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: 3 Widowed 4 Divorced Asian Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 6 Chef Restaurant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ping Chuen Tong Sau Wah Chan ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christina Tong/daughter 1516 December Drive #203 Silver Spring, MD 20904 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1
Department of F
Important: If ite
any injury or ot
once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Final Journey Crematory 1/5/2010 4 ☐ Donation 5 ☐ Other (Specify) Woodbine, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Going Home Cremation Service P.O. Box 784 M01251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part1. Enter the dease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Malignant carcinoma of the liver 1 month /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the furneral director, page 2 should be detached for use as the burish-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2∐xNo Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Hospice 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

2

Jocelyn Kouatchou, M.D. 6001 Muncaster Mill Road Rockville, Maryland 20855
31. Date filed (Month, Day, Year) 32. Degistrar's Signature.

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chou

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Koull

563748

January 1, 2010

10-00016 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Robin Lakeisha Trammell State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) Physician/ 2. Date of Death Month Day January 1, 2010 0820 hrs Medical Examiner Robin Lakisha Tramme11 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince Georges Hospital Center Prince George's 5. Social Security Number 7. Age (In yrs. last birthday) if Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Months Days Hours Director 218-08-8674 34 1 M 2 X F Nov. 14, 1975 Country) DC Usual Residence of Decedent 10d. Inside City Limits ď 10c. City, Town or Location 1 X Yes 2 No Maryland Prince George's notified at once. Suitland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5411 Morris Ave. Apt. 3 20746 United States Funeral 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 X Married 2 X No Yes Specify: African American 3 Widowed Divorced If Yes, Give Year 1 Yes 2 X No specify: è 16b. Kind of Business/Industry Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Completed Elementary/Secondary (0-12) College (1-4 or 5+) permit. Pages I and 2 should be filed within 72 P Department of Health and Mental Hygiene. Important: If item 27 is marked other than "" injury or other traumatic event, the Medical E Baltimore, MD 21215-0036 Clerk Private 12th 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Ronald Eugene Adams Shirley Graham 19a. Informant's Name/Relationship (Type, Print) ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3 Suitland, Md. 20746 James Harper Trammell/ Husband 5411 Morris Ave. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, January 20c. Location - City or Town, State 12. crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Heritage 2010 Waldorf, Maryland Donation 5 Other Specify: Signal re Fune Servi 22. Name and Address of Facility tewart unera ome, nc. 4001 Benning Rd. NE Washington, DC death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician failure. List only one cause on each line. Between Onset and /Medical Death Intracerebral hemorrhage complicating metastatic Immediate Cause (Final disease Examiner Due to (or as a consequence of): breast cancer or condition resulting in death) Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of) Examine cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and Physician/Medical AMENDED 23a,27,permE, tending physician a XUNPENDED g899 1/29/10 Box 68760, IF FEMALE 23d. Date of delivery 23c. If yes, outcome of pregnancy 3b. Was decedent pregnant in the 1 Live birth Fetal death Day Year 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 ✔ Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of After this certificate has performed' death? ✓ Yes 2 No 1 Yes No 25. Was case referred to medical 26.Place of Death (Check only one) Hospital. 1 Inpatient 2 🗸 ER/Outpatient 3 Other Nursing Home 5 Residence 6 Other 1 🗸 Yes 28a, Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural 1 Yes 2 No 5 Pending the 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 6 Could not be Suicide or Town, State) Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. January 2, 2010

State Registrar

OCME 2006

DHMH 17 Rev 1/2001

111 Penn Street, Baltimore, MD 21201

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

32. Registrar's Sign

Pamela E. Southall, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2010 00876 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Roger Wigley 2010 January Medical 2:48 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Harbor Hospital Social Security Number 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign **№** М 2 🗆 F Months Days Hours Country) Director 212-28-4849 79 09/24/1930 MD Usual Residence of Decedent ms 23a or 28a-f sho must be notified at 10c, City, Town or Location Director 10d. Inside City Limits 1 Yes 2 XNo MD Baltimore Halethorpe 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral filed within 72 hours after death with 4303 Washington Street <u>United</u> States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces Black, White, etc. 1 🔀 Yes 2 □ No 1953— If Yes, Give Year or Dates. 1955 ō 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Mechanic Automobile/Bus Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t. Page 1 and 2 should be fil tment of Health and Mental rtant: If item 27 is marked o ဂ Royal Hayes Wigley Louise R. Wells 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mark W. Wigley - son Department of Health Important: If item 27 any injury or other to 4311 Leola Avenue Baltimore, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 5 Other (Specify) Crownsville Vet. Cem. 01/07/2010 | Crownsville, MD 21. Signature of Funeral Sorvico Licensee 22. Name and Address of Facility Harry H. Witzke's Family F.H.Inc M01411 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final 3 Weeks Ph sician/ disease or condition Pancreatitis Medical resulting in death) Examiner Hypothermia 3 weeks Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or linjury that initiated events burial-transi and Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Pregnant at time of death Month Day Year 9 Unknown g Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No this certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director, After this certifics completed filled in by the funeral director, to **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other (Specify, and the second of the secon 1 ☐ Yes 2 No 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27 Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending injury Accident
Suicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Secretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number SERGE BELINGA, MD. **RES0001** January 2, 2010 241 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Serge Belinga, MD Harbor Hospital 3001 S. Hanover 31. Date filed (Month, Day, Year) 32 Registrar's Signatu State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 4a per dvr g899 1-29-10 vt
State of Maryland / Department of Health and Mental Hygiene
Amend Item 10f per fh,g899,01/29/2010dhb
Certificate of Death
Reg. No. 2011 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Рм Adams Virginia 8:00 Lee January 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 4913 East Chase 45-Chase St. Baltimore City Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Ye June 29, g. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛣 F Months Davs Hours Min Country) Virginia Director 213-34-7849 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD N/A Baltimore City Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 21205 United States 4913 East Chase Street 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Race - American Indian. Armed Forces?
1 ☐ Yes 2 💢 No Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: should be filed within 72 hours aft and Mental Hygiene. 'is marked other than "natural", If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates. White permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Years Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Ella R. Lanningham Robert E. Lee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4913 East Chase Street Baltimore, Maryland 21205 Donald Adams (Husband) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place, 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State Meadowridge Mem. Park 1/22/2010 Elkridge, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, 21. Signature of Funeral Service Licensee 7922 Wise Ave. Dundalk. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final e cwdra Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Drona Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Examir the Hospital or Attending Physician: The law requires that the death certificate be executed signed by the attending physician and deed be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Medical Records, P.O. Box 68760 IF FEMALE: Physician/ 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☒No
9 ☐ Unknown Day Month Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e, Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed should peen 24a. Was an autopsy performed? 24b. Were autopsy findings available cate has b prior to completion of cause of death? 1 Yes 2 No To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate completed filled in by the funeral director, pag X Yes 2 Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 \square Nursing Home 5 \bowtie Residence 6 \square Other (Specify) 1 ☐ Yes 2 🕏 No Hospital: ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d, Describe how injury occurred injury 1 🗹 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Cartifying Nurse Praction of Total Section of the cause of the time date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year) D34931 NNV 1116 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 Batimore, MD 21236 B Mrcall 4136 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year 2010 January Day **Physician** 15:30 PM Hoebanio VIAMOSTAPO YADAUC /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Agnes Hospital Baltimore Baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Sex 1 M 2 □ F Days 217 53 844 Hours Months Director NyeriA Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f shot other traumatic event, the "Assistal Examinar must be notified at 1 Yes 2 □ No Director UD10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 21113 Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status 1 ☐ Never Married 2 ☐ Married , o. 21215-0036 1 ☐ Yes 2 ☐ No Specify: δ 3 Widowed 4 □ Divorced 16 Ac Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) ESTATE h and Mental Hygier 7 is marked other to 1498/1 Maryland 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be HdebAN 2 DANTAR 19a. Informant's Name/Relationship 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MontgomeryVillage Creek D_{Γ} Department of Heal important: if item 2 any injury or other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location City or Town, State 20a. Methed of Disposition Date Pages 1 1 DBurial 2 ☐ Cremation 3 ☐ Removal from State thon Cen 1/23/2010 Clifton, 1 22. Name and Address of Facility MC + A St. 1-12-1 Clinton MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service hicansee 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Countrywood et LANDOUR Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Brain 2 days disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Right Mildle Cevebral Artery Territory Infaret
Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Hyper tension
Due to (dr &s a consequence of): burial-tran resulting in death) Last physician Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No the 9 Unknown 9 Unknown signed by to 4 debanjo, Sunday Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 1 □Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Momicide 24 hours a 152 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated To the Within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D0062273 Jan/17/2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, MD 21229 900 Caton Avenue Shahriar Amin, MO 31. Date filed (Month, Day, Year) 2. Registrar's Signature State JAN 2 U 2010 Registrar

			1 - For State Registrar	State of Mar		artment of I <i>rtificate of</i>	Health and M <i>Death</i>		giene Reg. No. 2	110	1 0	0870
			1. Decedent's Name (First, Middle, La	st)		Timodio or		2. Date of Dea	ath	1 0	3. Tin	ne of Death
	Physici /Medi		Clifford Leon	Atwell				Januar	y 11 2	Year 2010	8:1	LOa [™]
The same of	Examir		4a. Facility Name (If not institution, giv				or Location of Death		4c. County		h	
-			Carroll Hospital 5. Social Security Number 6. S		the same to a 4 h instruction of	Westmin If Under 1 Year		8. Date of Birt	Carro		hal /C	to to Countinu
	Funeral Director			$\stackrel{\text{dex}}{X}$ M 2 \square F 74	(In yrs. last birthday) Yrs.	Months Days	Hours Min.	Sept 1	y, Year)	9. Birti Co	nplace (Si untry) VA	tate or Foreign
	land ow		10a. State 10b. County	1	IOc. City, Town or Lo	ocation					10d. Insi	de City Limits
	Mary a-f sh	ţċ	MD Carroll		Woodbine						1 🗆	Yes 2∏No
	or 28%	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of \	What Co	untry?	
	23a (쿌	1303 Green Hill	Way		21797			USA	<i>A</i>		
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I're Medical Examinational Le notified at once.	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ev Armed Forces? 1 Yes 2 No If Xes, Give Year or Dates:	1958- 1962	Was Decedent of H If Yes, specify Cub 1 □Yes 2√2 No	Hispanic Origin? (Spe an, Mexican, Puerto I Specify:	ecify Yes or No- Rican, etc.)		ce - Ame ck, White Whi:		in,
21215-0036	2 hou atura	ted	15. Decedent's Ed	lucation	16a. Dece	dent's Usual Occup			16b. Kind of B			
218	thin 7 ie.	Completed	(Specify only highest gra	de completed) College (1-4or 5+)	life.	kind of work done DO NOT use retire	during most of workird)	ng	constru	ıcti.	on	
21	ed wii lygien ner th		8			penter					J11	
and	be fill ad ott ed ott	Be	17. Father's Name (First, Middle, Last) Luther Martin				18. Mother's Name Reva Virg			1e)		
ž	hould id Me mark matic	မ	19a. Informant's Name/Relationship (10h Maili	on Addross (Ctmst	and Number or Rura			Ctata :	Zio Codo)	
Maryland	nd 2 s ulth ar 27 ls rtrau		Mrs. Brenda L. At			_	11 Way, Wo				ip code)	
	s 1 ar		20a. Method of Disposition		20b. Place of Dispo			ate	20c. Location -		Town, Sta	te
Baltimore,	t. Page rtment c rtant: If njury or		1 MBurial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif	y)	Evergreen	Memoria	1 1-15-		Finksbu			
Bal	permi Depar Impor any Ir		21. Signature of Funeral Service Licer	/ 0	C		^{ess of Facility} Haig 195 Sykesv	,			Chap	el
			23a. Part 1. Enter the disease, or com shock, or heart failure. List only	plications that caused th one cause on each line.	ne death. Do not en	ter the mode of dyi	ng, such as cardiac o	or respiratory ar	rest,		Approx	l Between 🍃
· W . M	Physician		Immediate Cause (Final disease or condition	a. INTER	STITAL FO	en mounts	•				Onser	and Death
2.00	/Medical Examiner		resulting in death)	Due to (or as a	consequence of):							
		er	Sequentially list conditions, if any, leading to immediate	b	consequence of):							
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events		, ,							
oʻ	rificate be executed ng physician and as the burial-transit	Exa	resulting in death) Last	Due to (or as a c	consequence of):							
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	ertifica ling pl	Med	IF FEMALE:			-						
.O. Box	The law requires that the death certificate has been signed by the attending I page 2 should be detached for use as	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □No 9 □ Unknown	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at ti 9 Unknown	Fetal death 3	☐ Ectopic pregnand ☐ Other (specify) _	су			te of deli onth	ivery Day	Year
ď.	ires that signed b	by Pt	Part II. Other significant conditions of	ontributing to death but	not resulting in the u	nderlying cause giv	en in Part I.	23e. Did to	obacco use conf	ribute to	the cause	e of death?
rds	w requires s been sig should be		- PRIMARY	VENIENTIA				1 🗆 Y	'es 2□No	3 🗌 Pr	obably 4	4 🖰 Unknown
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Ä	: The l	ĕ							rmed?	death?	2 🖾 🌠	n of cause of
/ita	Physiclan: The this certificate ral director, pag	Be (25. Was case referred to medical examiner?				26. Place of Death					
£	ys dir	ဥ	1 ☐ Yes 2 ☑ 1√10	-	2 ER/Outpatier		4 LI Nursing Hor				cify)	
	ding Phy h. After thi funeral	ion	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day,)	(ear) 28b. Time o	Wor	k?	28d. Describe h	now injury occur	red		
Division	I or Attendi after death. Director; A d in by the fu	icat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be		- At home, farm, str]Yes 2□No	28f Location /6	Street and Numb	nor or Pr	um I Pourto	Number
<u>.</u>	Hospital or Attending 24 hours after death. Funeral Director: After tely filled in by the fune	Certification:	4 Homicide determined	building, etc.	(Specify)	oct, ractory, omoc		City or Tow		rer or ric	Tar House	realison,
	To the Hospital of within 24 hours af To the Funeral Discompletely filled in	Medical	29a. Certifier 1	ysician: To the best of niner: On the basis of e and manner state	xamination and/or in	h occurred at the ti vestigation, in my	ime, date and place, a opinion, death occurre	and due to the ed at the time,	cause(s) and m date and place,	anner as and due	stated. to the car	use(s)
	To the comp	Me	29b. Signature and title of certifier	1		29c. Licens	se number		29d. Date signe	d (Monti	n, Day, Ye	ar)
	()		fatel	/u		D	20806		1/11/	10		
	5 ×		30. Name and address of person who		th (Item 23a) (Type,		RO E	DeRSBU	RG UID	21	1784	
	Sta Registr		31. Date filed (Month, Day, Year)	2010 Lev	Signature A.	base			-,			
				-44-14		<u> </u>						

Registrar DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hydiene U

Certificate of Death Reg. No 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month 2:43PM helvir Physician 10 2010 lanvar /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner **Baltimore City** The Johns Hopkins Hospital If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday, 5. Social Security Number 6. Sex **Funeral** t**X** M 2 □ F 50 6-16-1959 214-82-7030 MD Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 X Yes 2 ☐ No MD Baltimore Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code 21213 U S 1634 Normal Avenue Α Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2**X** No 1 ☐ Yes 2X No Black Maryland 21215-0036 Specify Specify: þ 3 Widowed 4 N Divorced Year or Dates: 16b. Kind of Business/Industry Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Disabled 10th grade Disabled na 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental Elijah Ashley Josephine Wallace 0 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any injury or other trau once. Josephine Ashley-Mother 1634 Normal Avenue Baltimore, MD 21213 Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition
1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1-13-2010 Baltimore, Md Greenmount 4 ☐ Donation 5 ☐ Other (Specify) March East F/H 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 1101 E. North Avenue Balto, MD 21202 adus 9 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed physician and sthe burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical as attending IF FEMALE: use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy Month Day in the past 12 months? for Pregnant at time of death 5 Other (specify) 2 No detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 2 No page 2 should be 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate has 1 ☐ Yes 2 ☐ No 2 No or Attending Physician: 26. Place of Death (Check only one 25. Was case referred to medical Be examiner? Other: 4 \square Nursing Home 5 \square Residence _6 \square Other (Specify) 2 ER/Outpatient 3 🗌 DOA Inpatient ၉ 28c. Injury at Work? 28d. Describe how injury occurred funeral 28a. Date of Injury 28b. Time of 27. Manner of Death Certification: (Month, Day Year Injury 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No death. the after death Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined filled in by 4 - Homicide within 24 hours a

To the Funeral D

completely filled Hospital 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (check only one) the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie RES-000 January 10, 2010 completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St, Baltimore, MD, 21287 loanna M. Reloquin 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 20 2010 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month NORMAN ABRAHAMS JANUARY 1:45 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2303 BAYTHORNE COURT BALTIMORE BALTIMORE 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Months Days 1 X M 2 □ F Hours 141-22-9360 82 1/7/1928 Director MD Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Marylanc 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show **Funeral Director** 1 ☐Yes 2 🛛 No traumatic event, the Medical Examinar must be notified MD BALTIMORE 28a-f BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9 2303 BAYTHORNE COURT 21209 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 1 Never Married 2 Married Baltimore, Maryland 21215-0036 9 1 □Yes 2 No If Yes, Give Year or Dates: Specify: ģ 3 Widowed 4 Divorced WHITE Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) and Mental Hygiene. Elementary/Secondary (0-12) INVESTOR & BUILDER REAL ESTATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ALBERT မှ **ABRAHAMS** HANNAH **POMERANTZ** 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARILYN ABRAHAMS / WIFE 2303 BAYTHORNE COURT, BALTIMORE, MD 21209 other t 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of H
Important: If iter
any Injury or oth 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State BALTIMORE HEBREW 4 ☐ Donation 5 ☐ Other (Specify) 1/17/2010 REISTERSTOWN, MD 21. Signature of Funeral Service Licensee SOL LEVINSON & BROS. 8900 REISTERSTOWN ROAD, PIKESVILLE, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. or respiratory arrest. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine ificate be executed ing physician and as the burial-trans Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 □Yes 2 □ No g | Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an 1 □Yes 2 **N**O 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1□Yes 2XNo Hospital: Other: Medical Certification: To 4 ☐ Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 □Other (Specify)

To the Hospital or Attendl within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

Box	death cei	attendir d for use
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on of Vital Records, P.O. Box	ding Physician: The law requires that the death cer h.	After this certificate has been signed by the attendir funeral director, page 2 should be detached for use
Ital R	ian: The	ertificate h ctor, page
n of V	ng Physic	ofter this conneral dire
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27. Manner of Death

1 Natural 2 Accident

3 ☐ Suicide

29a, Certifier (Check only one)

4 Homicide

29b. Signature and the of certifier

Registrar

State

5 ☐ Pending investigation

6 ☐ Could not be determined

Date of Injury (Month, Day, Year)

License number

1 ☐Yes 2 ☐ No

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month. Day. Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Physician/ Medical 4b. City, Town, or Location of Death **Examiner** ounty of Death last birthday) 8. Date of Birth **Funeral** or Foreign Months **Director** 28a-f shov permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygene. Important: If item 23a or 28a-1 sho important: If item 27s is marked other than "natural", or items 23a or 28a-1 sho any hijury or other traumatic event, the Medical Examiner must be notified at any hijury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Completed by Funeral Director 1 Yes 2 No 10g. Citizen of What Country? Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces' 1 Never Married 2 Married 21215-0036 1 Yes 2 No Specify: If Yes, Give 3 ₩idowed 4 ☐ Divorced Year or Dates 16a. Dece en s Usual Occupation (Give king of work done during most of working life! DO NOT use retired) 15 Decedent's Education 8:50 (Specify only highest grade completed) Elementary/Seto ay (0-12) College (1-4 or 5+) Be Baltimore, Maryland er's Name (First, Middle, မ Number r Rural B 20a. Method of Dis Date remation 3 Removal Other (Specify) Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dy ng, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) DEMENTIA Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine tue to for as a nonsequence off cause. Enter Underlying Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 month Month Day Pregnant at time of death g Unknown completed filled in by the funeral director, page 2 should be detached g Unknown of Vital Records, P.O. been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform Director: After this certificate 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 X No Other: Certificate: To 4 Nursing Home 5 Residence 6X Other (Specify) HOSPICE 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes 2 No death Investigation 6 Could not be Accident Suicide Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined hours after within 24 hours a

To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

Registrar DHMH 17 Rev 7/2009

State

JANUARY

BEULAH BROOKS

VALLEY RD.

TIMONIUM, MD 21093

2300 DULANEY

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CRNP

JENNIFER HAUF

JAN 2 0 201

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygieney Certificate of Death 1 Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav **Physician** 1:00 A 2010 Vernon R. Brehm Jan 16, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Anne Arundel

9. Birthplace (State or Foreign
Country) 7346 Ridge Rd Hanover If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea Dec 9, 1929 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Davs Hours Min. 1 √M 2 □ F MD 218-26-5583 80 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show d other than "natural", or items 23a or 28a-f shovevent, the Medical Evaniner must be notified at 1 ☐ Yes 2☐ No Director MD Anne Arundel Hanover 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21076 USA 7346 Ridge Rd Funeral death \ 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ※XXX No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or ite 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 □Yes 2XXXNo If Yes, Give Year or Dates: Specify: Specify: \$ White 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bell Atlantic Telephone Lineman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frederick Brehm Bertha Mayer ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health an Important: If item 27 is any injury or other trau once. Edmund R. Brehm 6004 Bakers Pl, Hanover, MD 21076 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Surial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cemetery Jan 19, 201¢ Balto., MD 21. Signature of Funeral Service Licens 22. Name and Address of Facility
Fink Funeral Home, P.A. M01148 426 Crain Hwy S., Glen Burnie, MD 21061 23a. Part 1 Enter the dis ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or hear failur. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Tuse (Final disease or confilion resulting in death) **Physician** cnis /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): be execute attending physician and for use as the burial-transi Due to (or as a consequence of): P.O. Box 68760 Physician/Medical The law requires that the death certificate IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year cate has been signed by the page 2 should be detached ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed this certificate 2.0 No spital or Attending Physician: Theours after death, neral Director; After this certificate y filled in by the funeral director, pay 1 ☐ Yes 2 **☑**1Ño 1 Tyes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27 Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Hospital within 24 hours a To the Funeral C Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and the of certifie 29c. License number 30: Name and address of person who completed cause of death (Item 23a) (Type, Print) 100

DHMH 17 Rev 1/2001

State Registrar 32. Registrar's S

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 00884 State of Maryland / Department of Health and Mental Hygiene [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 9:30 A.M Mary Grace Boone January 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carroll Westminster Dove House 8. Date of Birth
(Month, Day, Year) If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. Social Security Number 6. Sex 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday **Funeral** 1 □ M 2\X Maryland Director 79 Yrs 214-28-5776 Usual Residence of Decedent fshow Page 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10d. Inside City Limits iral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location Director 1 🗆 Yes 💹 No Maryland Westminster Carroll 10e. Street and Number Unitied States? Funeral of America 1311 Arnold Road 21157 12. Was Decedent Ever in U.S. Armed Forces? 1947- If Yes, Give 195413. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. XX Never Married 2 Married <u>6</u> Baltimore, Maryland 21215-0036 1 ☐ Yes XX No Specify: Specify: White 3 Widowed 4 Divorced Completed Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+ 12th Accounting Accountant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Stephan Boone Laura Grabill 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Barbara Bingham (Life Partner)</u> 1311 Arnold Road, Westminster, Maryland 21157 20b. Place of Disposition (Name of Dufanety: Crematory of the place)
Dufanety Va71ey
Memorial Gardens 20a. Method of Disposition 20c. Location - City or Town, State Date Department of I Important: If ite any Injury or ot once. Jan. 20, 1XXBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 2010 Timonium, Maryland Stgmature of Fund of Service Licen 22. Name and Address of Facility Eckhardt Funeral Chapel, P.A. 11605 Reisterstown Road, Owings Mills, MD 21117 Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stock, or heart failure. List only one cause on each line. Approximate Interval Between s t and Death Ir mudiate Cause (Final Priysician None se or condition Medical resulting in death) Due to (or as a consequence of) Examiner Dequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events quentially list conditions, Due to (or as a consequence of): the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Year signed by the a d be detached f 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown cate has been sig ; page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 Yes 2 No Yes 2 N funeral director, To Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence To the Hospital or Attending Physic within 24 hours after death.

To the Funeral Director: After this ce completed filled in by the funeral dire 2 1 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending 1 🗌 Yes 2 🗎 No ☐ Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Physician Day DOLORES BARBARA BROCKMAN /Medical January 17, 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 4c. County of Death Baltimore

9. Birthplace (State or Foreign Country) Greater Baltimore Medical
5. Social Security Number 6. Sex 7. Age Center Towson If Under 1 Year Hours Min. 8. Date of Birth (Month, Day, Year)

Dec . 25, 1924 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2/CXF Months Days 219~18~0840 Director 85 Usual Residence of Decedent 10b. County 10c. City, Town or Location If Item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, it will did a few ring must be notified at Director Maryland Baltimore City Baltimore City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 5806 Comstock Avenue 21206 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status within 72 hours after 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 21215-0036 1 ☐ Yes 2 ☑ No Specify: ¾ Widowed 4 □ Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "any Injury or other traumatic event, it a liver applica-Elementary/Secondary (0-12) College (1-4or 5+) 12 yrs. N/A Clerk Canton Railroad 17. Father's Name (First, Middle, Last) Maryland 18. Mother's Name (First, Middle, Maiden Surname) Edward Steiner Mary Fousek ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) **BRO** Gloria M. Bilinski 2717 Sprague Avenue Waldorf, Md. 20601 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State XX Burial 2 Cremation 3 Removal from State Parkwood Cemetery 4 □ Donation 5 □ Other (Specify) 1~20~2010 Baltimore, Md. 21. Sign thre of Funeral Service Licensee 22. Name and Address of Facility Lassann Funeral Home 7401 Belair Rd. Bal Baltimore, Md. 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, i.e. Inc. 1. immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consoluence of executed and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, signed by the attending physician dbe detached for use as the burial Hospital or Attending Physician: The law requires that the death certificate be Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by RTEMY 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24a. Was an has autopsy performed? Yes 2 after death.

Director: After this certificate It in by the funeral director, page 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ■ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Matural 5 Pending investigation

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #19b Per FH G899 1/20/2010 JH State of Maryland / Department of Health and Mental Hygiene?

Certificate of Death

2. Date of Death

00885

3. Time of Death

10d. Inside City Limits

Approximate Interval Between Onset and Death

DAY

Year

24b. Were autopsy findings available prior to completion of cause of death?

2010

1 ☐ Yes 2 Dolo

1 □ Yes 2 □ No

6:21 A M

Year

Maryland

14. Race - American Indian Black, White, etc.

23d. Date of delivery

Month

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed, (Month, Day, Year)

White

2010

n 24 hours af ie **Funeral D**i etely filled ir

within 2.

ical

State Registrar 2 Accident

4 Homicide

3 ☐ Suicide

29a, Certifier

29b. Signature

DAVID

6 ☐ Could not be

STRAUSS

1 - For State Registrar

1. Decedent's Name (First, Middle, Last)

6701 N CHarles G. B. M. C. 31. Date filed (Month, Day, Year) 32 Registrar's Signature JAN 20 back

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐Yes 2 ☐ No

29c. License number D 0022657

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

10-00424 Edna E. Bennett Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2 0 | 0 State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar		(Certific	ate of	Death			- F	Reg. No.		
Physicia Medical Exami	an/	1. Decedent's Name (First, M Edna E. Be								Date of Dea Month January 1	Day Year 5, 2010		3. Time of Death 0630 hrs
)		4a. Facility Name (if not instit Doctors Community		ımber)		41	o. City, Town, o Lanham	r Location	of Death		4c. County o		3
Funeral Director		5. Social Security Number 180–30–8016	6. Sex	7. Age (In)	yrs. last birt	hday) Yrs.	If Under 1 Ye		er 24Hrs. Min.	8. Date of Bi	rth(MM/DD/YYYY) 1942	Foreign	place (state or West ^{ltry)} Virginia
ow any		Usual Residence of Deceden 10a. State 10b. Cour	nt nty		City, Town		n					1	Od. Inside City Limits 1 Yes 2 No
Maryland r 28a-f show	Director	MD 10e. Street and Number 9901 Treetop Lan	PG		Lanham		10f. Zip Code	 706			10g. Citizen of Wh		71
y, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland tealth and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at once.	Funeral Di	11. Marital Status 1 Never Married 2	12. Was Dec				Decedent of Hi s, specify Cuba	spanic Orig			White	etc.	an Indian, Black,
after al",	ā	3 X Widowed 4 15. Decedent's Education (5	Divorced If Yes, Give Yes or Dates:	ar			Yes 2 X No			rk done	Specify: I		lustry
hin 72 hou e. than "nai edical Ex	ompleted	Elementary/Secondary (0-	12) College (1	I-4 or 5+)		during mo:	st of working life	, DO NOT	use retire	d)	Federal	Cover	ment
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur injury or other traumatic event, the Medical Exam	Be Con	17. Father's Name (First, Mid William Evans	dle, Last)							irst, Middle,	Maiden Surname)	abra	
MD 21 id 2 should b alth and Men m 27 is mar		19a. Informant's Name/Relation				_	Address (Stre	et and Nun	nber or Ru	ral Route Nu	mber, City or Town	ı, State, Z	Zip Code)
lore, Nges I and to of Health		20a. Method of Disposition 1 Burial 2 Crema	ition 3 Removal fr	om State	cremate	ory or othe	ion (Name of ce er place) Cerreter		01/22	Date /2010	20c. Location -		
Baltimore, permit. Pages lar Department of Hee Important: If ite	ł	4 Donation 5 Other 21. Signature of Funeral Serv	r Specify: rice Licensee	<u> </u>]	NesuLiv	22. Na	me and Addres	s of Facility	Free	an Funer	ral Service 4D 20748		au .
Physician /Medical		23a. Part Enter the disease failure. List only one car	use on each line.									rt	Approximate Interval Between Onset and
Examiner		Immediate Cause (Final disea or condition resulting in death		consequen	ce of):	lar Dise	250						Death
	miner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cau	Due to (or as a			141 5100	<u></u>						
outed nd ransit	Exa	events resulting in death) Last Due to (or as a consequence of):											
760, Ticate be executed physician and the burial - transit	/Medical	UNPENDED IF FEMALE:	AMENDED 23c. If yes,	outcome of	pregnancy						23d. Date of o	delivery	
Sox 68 leath certif e attending for use as	Physician/	23b. Was decedent pregnant i past 12 months?	n the 1 Live b	eirth ant at time o	2		I death 3 er (Specify)	Ectopio	pregnanc	су	Month	Day	y Year
, P.O. E	ρ	Part II. Other significant con	nditions contributing to	death but r	not resulting	j in the un	derlying cause	given in Pa	nrt I.		obacco use contrib	-	e cause of death?
of Vital Records, ng Physitian: The law require ther this certificate has been si meral director, page 2 should b	ompleted								_	24a. Was autop perfo 1 ✓ Yes	osy pr rmed? de		osy findings available inpletion of cause of
Vital Re- ysician: The his certificate director, page	o Be C	25. Was case referred to med examiner?		npatient 2	ER/OL	utpatient		of Death Other			Residence 6	Other:	
ion of V tending Phy eath. for: After th	-		28a. Date			Time of Inj	ury 28c. Inju	iry at Work Yes 2	? 2		how injury occurre	d	
Division pital or Attendiurs after death.	ertification:	3 Suicide 6 C		e of Injury -	At home, fa	rm, street,	factory, office l	ouilding, et	c. 2	8f. Location (: or Town, \$		r or Rural	Route Number, City
Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rura or Town, State) 28f. Location (Street and Number or Rura or Town,													
	Ž	29b. Signature and title of cer	rither ruthall, m	1)			29c. Licens O.C.				January 19,		, <i>Day</i> , Year)
101	_	30. Name and address of personal Parnela E. Southall				r 111	Penn Stree	t, Baltim	ore, MD	21201	•		
St Regist	~~~	31. Date filed (Month, Day, Ye		egistrar's Sig	nature	all	0						
DHMH 17 Rev 1/20 OCME 2006	001	an.		,	OR	IGINAL					OCME		

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ROSA OPHELIA BATTLE Day 15, 2010 January 0215 A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital Takona. 5. Social Security Number . Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min. (Month, Day, Yea 03/17/1923 1 ☐ M 2√2 F Months Hours 86 Virginia Director 579-30-6650 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location ms 23a or 28a-f sho must be notified at 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Director D.C. Washington 1 🔀 Yes 2 🗌 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 326 Bryant Street, N.E. 20002 U.S.A. items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian. Black, White, etc. ,0 þ 1 Never Married 2 Married 1 Yes If Yes, Give 2 🔀 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: Black "natural" 3 🔀 Widowed 4 🗆 Divorced Completed Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Coook Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Richard Vauchn Maggie Nash 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1121 'Tewkerbury Place, NW; Washington, DC 20012 Lewis Dawkin — Son 20b. Place of Disposition (Name of cemetery, crematory or other place)
Fort Lincoln Cemetery 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 01/22/2010 Brentwood, Maryland 22. Name and Address of Facility Freeman Funeral Services Signature of Funeral Service Licensee Hulmur 4594 Heach Road; Temple Ffills, Maryland 20748 23a. Part 1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ejysician/ disease or condition **∠**Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Year 1 ☐ Yes 2⅓ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 ☐ Yes 2 ☐ No 25. Was case refer 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 🗌 Yes 2 No Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of fertifie 29c. License number 29d, Date signed (Month, Dav. Year)

State Registrar

Barks

4701 Randolph Road sto 216; Rockville,

person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Zuniya

MD

Amend #5, per th g901 3/17/10 III amend #23a 23P11 Per PHY E90173/2674 th And Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Year 04 **Physician** YON-TH /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Randallstown Baltimore Seasons Hospice If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, Date of Birth (Month, Day, Year) Funeral Days Hours Months 1 □ M 2 🖫 F 49 Yrs 153-62-4728 Director 10-22-1950 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modest Experiment 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 1 ☐ Yes 2 No Director Reisterstown MD Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21136 USA 12606 Mount Laurel Court Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married African-American 1 ☐ Yes 2 No Specify: Specify Completed by 3 ☐ Widowed 4 ☐ Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Baltimore County Attomey 5+ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Carolyn Perry Dr. Peter N. Britton Jr. ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1133 Martine Avenue, Scotch Plains, NJ 07076 Carolyn P. Britton/ Mother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Scotch Plains, NJ 1-23-10 Hillside cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Whie Fineral Home P.A. of Baltimore Co. sclow 9200 Liberty Road, Randallstown, MD 21133 23a. Part L Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause en each line. Approximate Interval Between Onset and Death Osteosarcomatous Cancer Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner executed and burial-tran Due to (or as a consequence of): Box 68760, attending physician for use as the buria requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 4 Pregnant at time of death 5 Other (specify) been signed by the should be detached o 9 Unknow ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, Be Completed by Peritoneal Carcinomatosis 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Physician: The law has page 2 autopsy performed certificate 1 ☐ Yes 2/2 No 1 ☐ Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other (Specif Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation Natural 1 Yes 2 🗆 No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier address of person who completed cause of death (Item 23a) (Type, Print 0 32. Registrar's State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month anuari Hazel L. Bartee 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Hours | Min. | (Month, Day, Year) | 6-17-1925 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Months 1 □ M 2 😾 F 84 Yrs. VΑ 219**-**Ĭ8-0463 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County XXYes 2 ☐ No Baltimore n/a 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 939 McAleer Ct 21202 US 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 If Yes, Give 1 ☐ Never Married 2 ☐ Married 1 ☐Yes 2 X No Black Specify Specify 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) J. H. H. 10th grade Laundry na 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lena Holmes Alex Neal 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rev. Floyd Neal-Son 939 McAleer Court Balto, MD 21202 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify) 3 Removal from State 1-19-2010 Randallstown, MD Memorial Pk 21. Signature of Funeral Service 22. Name and Address of Facility March East F/H Balto, 1101 E. North Avenue MD 21202 Approximate Interval Between Onset and Death Part 1. Enter the disease, or complikations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown 3 Ectopic pregnancy Month Year Day 5 Other (specify) 1 □Yes 2 □ No

Physician) /Medical **Examiner**

Physician

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any lijury or other traumatic event, it is Maricel Examiner must be refitted anonce.

21215-0036

Maryland

Itimore,

P.O. Box 68760,

Division of Vital Records,

/Medical

10a. State

MD

Funeral Director

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Completed

Be

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Examiner

Be Completed by Physician/Medical

Certification: To

Medical

29b. Signature and title of certific

vate has been signed by the attending physician and page 2 should be detached for use as the burial-trar certificate

or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral director. To the Hospital

Part II. Other significant conditions of	ontributing to death but not res	ulting in the underlying	cause given in Part I.	23e. Did tobacco u 1 ☐ Yes 2 [se contribute to the cause of death? No 3 Probably 4 1 Unknown				
				24a. Was an autopsy performed? 1 □ Yes 25 No	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No				
25. Was case referred to medical		26. Place of Death (Check only one)							
examiner? 1 ☐ Yes 2 No	Hospital: 1 Inpatient 2	ER/Outpatient 3□	DOA Other: 4 Nursing	Home 5 ☐ Residence 6	S ☐ Other (Specify)				
27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury	28d. Describe how injury occurred				
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Speci		28f. Location (Street and Number or Rural Route Number, City or Town, State)						

29c. License number

89616

29d, Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

and manner stated

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JOHN BONSUK 9:08 AM 2000 January Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HARbOR HOSDITA BALTIMORE N/A Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🕱 M 2 🗆 F Months Hours Min. Month, Day, Year) Country)
Marvland 213 14 7544 87 Director Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location with the Maryland r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10d. Inside City Limits Director Maryland Anne Arundel Baltimore 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 504 Matthews Avenue 21225 U.S.A. 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, rmed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 Yes 2 No Specify: Specify: Completed 3 XWidowed 4 Divorced WW II White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Multi - Mechanic W.R. Grace 8th other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Harasin Bonsuk Pauline Petrishin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Joseph Bonsuk / Son 504 Matthews Avenue Baltimore, Maryland 21225 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) MD State Veteran Cem; 01/26/2010 Crownsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Signature of Funeral Service Gonce Funeral Service, P.A. 4001 <u>Ritchie Highway</u> Baltimore, Maryland 21225 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. nset and Death Immediate Cause (Final DNEUMONIA SPIRATION Physician disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) and -transit Exami Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IE EEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Pregnant at time of death Yes 2 No signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ RENAL PAILURE 1 ☐ Yes 2 Mo 3 ☐ Probably 4 ☐ Unknown s been signal Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an s certificate has the lirector, page 2 s autopsy death? 1 ☐ Yes 2 🗹 No Yes 25. Was case referred to medical director æ 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 M No 1 🗌 Yes မြ 1 MInpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 5 Pending To the Hospital or Attendir within 24 hours after death.
To the Funeral Director, Af completed filled in by the fu death. 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES 000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD, 3001 South HANOVER Street, BAltiMORE, MD, 21225 POZDEYEV, 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

			For State Registrar	State of	f Marylan		artment of F		d Mental Hy	giene 20	10	00891	
	Physicia		1. Decedent's Name (First, Middle Shirile		ue				2. Date of Do	eath Day	Year	3. Time of Death	_
40	/Medic Examin		4a. Facility Name (If not institution				4b. City, Town, o	r Location of D		4c. County of		1200.	_
**			Howard County		ospital			olumbia		Hov	vard		_
	Funeral Director		5. Social Security Number 212–34–1296	6. Sex 1 □ M 2 🔀 F	7. Ağe (<i>In yrs.</i> 1	last birthday) Yrs.	If Under 1 Year Months Days	Hours N	Min. 8. Date of Bi Month, D March	1'9', 1936	9. Birthpla Countr	Maryland	
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	f sho	to		ward			lkridge					1 □Yes 2 No	
-	r 28a	Director	10e. Street and Number	waru			10f. Zip Code			10g. Citizen of W	nat Countr	y?	-
4	23a c		7236 Montgomer	y Road, A	pt 2D		2107	75		United	Sta	tes	
,	rier dea	Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Marr	Armed Foi ied 1 ☐ Yes	2 No		f Yes, specify Cuba	an, Mexican, Pu	? (Specify Yes or N uerto Rican, etc.)		- America , White, et		
3	s Tario z should be liled within 7∠ hours after death with the maryland the and Mental Hygiene. The Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Evan had must be notified at	d by	3 ☐ Widowed 4 ☐ pivorced	If Yes, Giv Year or Da	/e		I □Yes 2 ☑No	Specify:		Specify:		ite	
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מו אַ	shour and M s mar	욘	19a. Informant's Name/Relations			19b. Mailir	ng Address (Street	and Number o	r Rural Route Num	ber, City or Town, S	State, Zip (Pode)	-
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			23a. Part 1. Enter the disease, or shock, or heart failure. List	complications that conly one cause on e	aused the death ach line.	n. Do not ent	er the mode of dyir	ng, such as car	rdiac or respiratory	arrest,		Approximate nterval Between Onset and Death	
	hysician /Medical		Immediate Cause (Final disease or condition resulting in death)	Oi,	COMPENS		liver ci	rhosir					_
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	attending p	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live b	come of pregna pirth 2□Feta nant at time of d	Ideath 3	Ectopic pregnand Other (specify)	у		23d. Date Mon	of deliver th	y Day Year	
) å	by the tached	hysi	9 ☐ Unknown	9 ☐ Unkn									_
The law requires that the death certifi	signed	by	Part II. Other significant condition	ons contributing to de		ulting in the ur	nderlying cause giv	en in Part I.		tobacco use contri Yes 2 □ No		cause of death?	
5	s peen s	letec		J					24a. Wa	s an 24b. W	ere autop	sy findings available	
The la	cate has	Completed							peri	ormed? de	eath?	pletion of cause of	
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Attending	ath. r: Afte e fune	ation	1 Natural 5 Pending 2 Accident investig	g (Mont	h, Day, Year)	Injury	Wor	ḱ? Yes 2 □ No	200. 20000				
or Atte	within 24 hours after death. To the Funeral Director: After completely filled in by the funeral process.	Certification:	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	not be ined 28e. Place building	of Injury - At hong, etc. (Specif	ome, farm, stroy)	eet, factory, office		28f. Location City or To	(Street and Numbe own, State)	r or Rural	Route Number,	
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	0.1		30. Name and address of person	who completed caus						2011	14	2010	_
l	0 \		Nishi Rawat, M	I.D. 10710	Charte	r Driv	ŕ	#310	Columbia.	Marylan	1 210	44	
	Sta Registra	/	31. Date filed (Month, Day, Year)	0 2010 32. R	gistrar's Signa	ture							
			**************************************	- FAIR M	-	10. 14	and the second						_

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician 2010 Jacuan /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltruck lledico If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month Day 5. Social Security Number **Funeral** Hours Min. Months Days Director idence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1. Yes 2 □ No Completed by Funeral Director 10g. Citizen of What Country? 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. 12. Was Decedent Ever in U.S. Armed Forces? Yes 2 □ No if Yes, Give Year or Dates: 14. Race - American Indian 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes No Kilk Specify: 3 Widowed 4 Divorced "natural" er than "nature , the Medical E 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life 50 NOT uservetired) /Secondary (0-12) College (1-4or 5+) If Item 27 is marked other or other traumatic event, I 17. Father's Name Be nformant's Name/Relationship (Type. 19b. Mailing Address (Street and Number or Rural Route Number 20b. Place of Di cemetery, 20c. Location -Method of Disposition Department of Important; If it any injury or conce. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each line. mmediate Cause (Final **Physician** disease or condition resulting in death) /Medical uisv fileie a Examiner Scuerfielly list continued it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year 5 ☐ Other (specify) 1 □Yes 2 □ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 🗆 No 1 ☐ Yes 2 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 🗆 Yes 2 🗆 No 6 ☐Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29d., Date signed (Month, Day, Year) 29b. Signature and title of certifier 15 10 (Item 23a) (Type, Print) 30. Name and address of pers on who completed cause of death Morte

State Registrar 31. Date filed (Month, Day,

Year)

32. Regist

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Physician
/Medica
Examine

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executer within 24 hours after death. Division of Vital Records, P.O. Box 68760,

Physicia	9	1. Decedent's Name (First, Middle, Last)	n Fox B			2. Date of Death _ Month	Dav. Year	3. Time of Death		
/Medic		Anr		January	16, 2010	7:05 P ^M				
Examin	er	4a. Facility Name (If not institution, give street and number)			r Location of Death		4c. County of Death			
/		Brooke Grove Rehab and Nurs		3			Montg			
Funeral Director		029-12-3224 1□ M 2፟Ø F	e (In yrs. last birthda 85 Yrs	Months Dave	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,) July 27,	1925 Cana	lace (State or Foreign try) da		
and		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or	Location			11	Od. Inside City Limits		
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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examitive ment for infinitial at once.	by	Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 ☑ N If Yes, Give Year or Dates:	10	1 ☐ Yes 2X No	an, Mexican, Puerto Specify:	Hican, etc.)	Black, White, e	White, etc. White		
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should Me Me mark	ည	19a. Informant's Name/Relationship (Type. Print)	19b. M	ailing Address (Street			City or Town, State, Zip	Code)		
and 2 s lealth ar m 27 is her trau		Barbara B. Perretta / Daug	hter 3 Ho	neystone (Court, Bro	ookeville	, Maryland	20833		
Pages 1 ment of H ant; If ite ury or ot		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)		sposition (Name of crematory or other place ph Cemete:		iry 23, We	oc. Location - City or To est Roxbury assachusett	,		
permit. Depart Import any Inj once.		21. Signature of Funeral Service Licensee	M01305	22, Name and Addre Robert A. Pur 300 West Mont	ss of Facility Inphrey Funer Igomery Aven	ral Home/Ro ue, Rockvi	ckville, Inc. lle, Maryland	20850-2805		
Physician		23a. Part 1. Inter the disease, or complications that caused shock, r heart failure. List only one cause on each lir Immediate Cause (Final disease or condition	the death. Do not	enter the mode of dyir		or respiratory arres	ıt,	Approximate Interval Between Onset and Death		
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2160	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, (Disease or Injury	a consequence of):	N OKLIN	SIVE E	HSEASE				
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aw requir as been s 2 should	Completed					24a. Was an	24b. Were auto	osy findings available		
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hysic this o		1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatie	nt 2 🗆 ER/Outpa		4 AJ Nursing no	me 5 Residen	ce 6 ☐ Other (Specify)		
ling P	ion:	27. Manner of Death 1 Death September 28a. Date of Injury 1 Natural 5 Pending (Month, Day)		y Worl		28d. Describe how	injury occurred			
death death ctor: / the	icat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 28e Place of Inju	Irv - At home farm	M 1 □ street, factory, office	Yes 2 □No	28f Location /Stro	et and Number or Rura	I Bouto Number		
al or A after I Direct	Certification: To	4 Homicide determined 200. Place of IIII. building, etc.	. (Specify)	Street, lactory, office		City or Town,		noute Number,		
To the Hospital or Attending Physician: The law requires that the d within 24 hours after death. To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached	Medical (29a. Certifier (Check only one) 1 Certifying Physician: To the best of 2 Medical Examiner: On the basis of and manner sta	examination and/o	eath occurred at the ti r investigation, in my c	me, date and place, ppinion, death occur	and due to the cau red at the time, dat	use(s) and manner as s e and place, and due to	ated. the cause(s)		
To th within To th	Me	29b. Signature and title of certifier		29c. Licens	e number	290	d. Date signed (Month,	Day, Year)		
		> Jacoue m	>	D33	700	TA	NUARY 18.	2010		
6.		30. Name and address of person who completed cause of de		oe, Print)						
5v		TED E. HOWE 154 N. A	RTIZAN	ST,	Williams	SPORT, 1	115 an	95		

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ JANUARY 18 2010 LOTTIE BRENNER 5:30 Αм Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death ENVOY OF PIKESVILLE PIKESVILLE BALTIMORE Social Security Number 9. Birthplace (State or Foreign Country) MD 7. Age (In yrs. last birthday) if Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 1 - M 2 X F Months 217-38-2209 102 Yrs. 1071171907 Director Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director BALTIMORE 1 X Yes 2 No N/A 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4122 FALLSTAFF ROAD 21215 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc ģ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates Specify Completed 3 X Widowed 4 Divorced Specify: WHITE 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME of Health and Mental Hygi item 27 is marked other other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Ments Important: If item 27 is marked any injury or other transcone. ဂ MEYER COHEN HANNAH MURDRICK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ARNOLD BRENNER / SON 113 DANBURY ROAD, REISTERSTOWN, MD 21136 Baltimore, 20b. Place of Disposition (Name of OHR^{en}KNESSETHO TISRAEL ANSHE SFARD CONG. 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1/19/2010 BALTIMORE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) 16017 Medical Due to (or as a consequence of) Examiner theroscle lears Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical P.O. Box 68760 IF FEMALE: 23c, If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ♣No 5 Other (specify) Month Day Pregnant at time of death 9 Unknown been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Tes 2 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has ral director, page 2 autopsy death? 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medica Be 26. Place of Death (Check only one) 2 **Z** No Other မ 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) within 24 hours after death.

To the Funeral Director: After th completed filled in by the funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Spec/fy) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 1737573 January 18, 2010 30. Name and address of person who con leted cause of death (Item 23a) (Type, Print) Zikell 25 Mai Reisberste ていろく

Registrar DHMH 17 Rev 7/2009

State

Date filed (Month)

32. Registrar's Signature

51.

MD

	FOI	epartment of Health and M Certificate of Death	ental Hygiene Reg. No. 201	00895
Physician	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year	3. Time of Death
/Medical	Michael Allen Beck 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	January 16, 2010	8:00 A M
Examiner	3400 Baywood Drive	Forest Hill	Harfo	
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthe	Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 9. Bi	rthplace (State or Foreign country)
Director	212-44-4711 11XIM 2 F 63 Yr Usual Residence of Decedent	S.	June 10, 1946	Maryland
yland	10a. State 10b. County 10c. City, Town of	r Location		10d. Inside City Limits
or 28a-f st or 28a-f st be notified Director	Maryland Harford Forest			1 □Yes 2 ☑ No
uth with the Marylan 23a or 28a-f show ust be notified at ral Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What C	ountry?
r items 23a	3400 Baywood Drive 11. Marital Status 12. Was Decedent Ever in U.S.	21050 13. Was Decedent of Hispanic Origin? (Spe	usa ecify Yes or No- 14. Race - Am	erican Indian,
II", or	Armed Forces? 1 ☐ Never Married 2 ☑ Married 1 ☒ Yes 2 ☐ No If Yes, Give Year or Dates:	If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☑ No Specify:	Rican, etc.) Black, Whi	te, etc. White
permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", any injury or other traumatic event, Its Medical Exa once. To Be Completed by	(Specify only highest grade completed)	ecedent's Usual Occupation Give kind of work done during most of workli ife. DO NOT use retired)	16b. Kind of Business	s/Industry
d with giene.	Elementary/Secondary (0-12) College (1-4or 5+)	wner/Operator	Painting	Company
be file d oth d oth event	17. Father's Name (First, Middle, Last)		(First, Middle, Maiden Surname)	
d Men marke matic	Robert David Leroy Beck 19a. Informant's Name/Relationship (Type. Print) 19b. N	Mailing Address (Street and Number or Rura	atherine Macalhan	
nd 2 sl alth an 27 is r r trau		00 Baywood Drive, Fo		
item item	20a. Method of Disposition 20b. Place of Disposition		Pate 20c. Location - City o	
Page ment ant: If ury or	I Buriai 241 Cremation 3 Li Removal from State	Service Corp. 1-19	9-10 Towson, M	arvland
permit. Depart Import any inj	21. Signature of Funera Service Ocensee	22 Name and Address of Facility McComas Funeral Hon 50 W. Broadway, Bel	ne, P.A.	-
	23a. Part 1. Enter the disease, or complications that caused the ceath. Do no shock, or hear failure. List only one cause on each line.	t enter the mode of dying, such as cardiac of	or respiratory arrest,	Approximate Interval Between Onset and Death
Physician	Immediate Cause (Final disease or condition resulting in death)			2 years
/ /Medical Examiner	Due to (or as a consequence of)	:		
ner ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	:		
be executed ician and burial-transit	that initiated events c.			
	resulting in death) Last Due to (or as a consequence of)	:		
ificate physics the last the last the legical edical	d			
Attending Physician: The law requires that the death certificate be refort. After this certificate has been signed by the attending physici by the funeral director, page 2 should be detached for use as the builfication: To Be Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	23d. Date of d Month	elivery Day Year
w requires that the de been signed by the should be detached	Part II. Other significant conditions contributing to death but not resulting in t	he underlying cause given in Part I.	23e. Did tobacco use contribute	to the cause of death?
equires en sig ould by			1 Yes 2 No 3 □	Probably 4 Unknown
: The law requii cate has been s page 2 should			24a. Was an autopsy performed? 1 Yes 2 4b. Were a prior to death?	
ician: The certificate rector, pag	25. Was case referred to medical examiner?	26. Place of Death		
Physi this cral dire	1		me 5 Residence 6 □ Other (Sp. 28d. Describe how injury occurred	pecify)
ending eath. or: After the funer	1 Matural 5 Pending (Month, Day, Year) Inj 2 Accident investigation		2ad. Describe now injury occurred	
tal or Attending P Is after death. al Director. After ided in by the funers Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)	n, street, factory, office	28f. Location (Street and Number or I City or Town, State)	Rural Route Number,
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director, Medical Certification: To Be (29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, 2 Medical Examiner: On the basis of examination and and manner stated.			
To the company of the	29b. Signature and title of certifier	29c. License number	29d. Date signed (Mo	
at all	7	Data.		
2	31. Date filed (Manua, Deveryon) 32 Registrar's Signature	3 Franklin Sj pr.	Baltimer MD	2123+
State Registrar	30. Name and address of person who completed cause of death (frem 23a) (1	bare		

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 30 per dvr g899 1-20-10 vt
State of Maryland / Department of Health and Mental Hygiene State
Registrar Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month Day Curtis Emmitt Cassell Year 1945 2010 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Memori Easton If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 🔀 M 2 🗆 F Min. Months Hours (Month, Day, Year) 8 / 9 / 28 Country) 81 057-24-7872 Director Yrs WV Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits NY Wayne Lyons 1 🗆 Yes 2 🗆 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral USA 11 North Canal Street 14489 ral", or items 2 Examiner mus Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12, Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?
1 ☐ Yes 2X XNo Black, White, etc. 1 Never Married 2 Married be filed within 72 hours after 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates White d Mental Hygiene. marked other than "natural", 3X Widowed 4 □ Divorced permit, Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Various Elementary/Seconday (0-12) College (1-4 or 5+) Construction Construction Worker 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Sarah Etta Lambert Homer Henry Cassell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) daughter 29689 Charles Drive Easton, MD 21601 Lucille Cassell Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State st. Mary's Cemet. 1 XBurial 2 Cremation 3 Removal from State 1/22/10 Rye Brook, NY 4 Donation 5 Other (Specify) 21. Signature of Fundial Service Licensee 22. Name and Address of Facility Joseph Tutera Funeral Home NY 10E South Regent St. Port Chester, 121 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph sician/ Obstructive disease or condition resulting in death) Medical Examiner ue to (or as a consequence of) malshive Heart Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to of as a consequence of): ST elevation use as the burial-transi Cause (Disease or linjury been signed by the attending physician and should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Pregnant at time of death Day Year Yes 2 No 1 ☐ Yes 2 ☐ Unknown that the o Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Widner Hospital or Attending Physician: The law requires Division of Vital Records, 1 ☐ Yes 2 Ø No 3 ☐ Probably 4 ☐ Unknown completed filled in by the funeral director, page 2 should nai 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has performed? Yes 2 X N 1 Yes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No å 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 N Inpatient 2 ER/Outpatient 3 DOA After this Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred 1 Matural 2 Accident injury 5 Pending Investigation after death Director: 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) KMohan MN 00069567 18, 2010 Lanuary 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20 219 s. Washington St. Easton, Md. 21601 Ravi Mohan 31. Date filed (Month, Day, Year) State JAN 20 2010 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		_	For State Registrar		Cei	rtificate of E			Reg. No. 201	0 00897					
	Physicia	n/	1. Decedent's Name (First, Middle, Last) Kenneth	Eugene	Cox	Jr.	2, Date of Dea	Day Year						
	Medic Examin		4a. Facility Name (if not institution, give			4b. City, Town, or		January	y 14, 2010 4c. County of De	7:58 A ^M					
1			3117 Greenhill R	load			mere		Baltimo						
	Funeral		5. Social Security Number 6. Se	Лма∏Е	In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	0 P	irthplace (State or Foreign					
	Director		168-60-8272 Usual Residence of Decedent	45	5 Yrs.			Dec. 1	(, Year) 0, 1964	Pennsylvania					
	land show dat	tor	10a. State 10b. County	1	10c. City, Town or Lo	cation				10d. Inside City Limits					
	Mary 28a-f otifie	Director	MD Baltin	nore		_	Edgem	ere		1 🗆 Yes 2 🖾 No					
	th the	al D	10e. Street and Number			10f. Zip Code			10g. Citizen of What C	Country?					
	ath wil	Funeral	3117 Greenhill	Road 12. Was Decedent Eve	or in H.C. 12.1	Vas Decedent of His f Yes, specify Cubar		oif. Van av Na	United St						
ပ္	er dez or ite miner	14. Race - Am Black, Whi													
03	ırs aft ural", IExa	ted by	3 Divorced	1 X Yes 2 □ No If Yes, Give Year or Dates. 19	. 1	1 ☐ Yes 2XXNo	Specify:		Specify:	White					
Maryland 21215-0036	72 hours after death with the Maryland "natural", or items 23a or 28a-f sho fedical Examiner must be notified at	Completed	15. Decedent's Ed (Specify only highest grad	ucation de completed)	(Give	dent's Usual Occupa kind of work done d	ition uring most of worki	ng I	16b. Kind of Business	s Industry					
12	within 7 giene. ier than t, the M	Con	Elementary/Seconday (0-12) 12 Years	College (1-4 or 5+)		O NOT use retired)			A G						
d 2	iled w I Hygi othel rent, i	Be	17. Father's Name (First, Middle, Last)	2 Years	. I Huji	an Resour	18. Mother's Name	e (First, Middle, I	Aviator Sa Maiden Surname)	areguard					
/lan	d be filed Mental Hy arked oth	욘	Kenneth E. Cox,	Sr.			Donna	J. Berl	kheimer						
lan	should I and Me is marl raumati		19a. Informant's Name/Relationship (Typ	•	-			City or Town, State, Z							
€,	and 2 s Health tem 27		Mrs. Linda M. Cox	(Wife)		Greenhil	1 Road	Edgemer	e, Marylan						
סר	Page 1 ann of hant of hant: If ite		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐		* .	natory or other place	9)	Date	20c. Location - City of	,					
Description of the property of										e, Maryland					
B	permit. Departr Importa any inji	. //	NA	The					Dundalk,						
ı			23a. Part 1. Enter the disease, or comp shock, or lieart failure. List only on	lications that caused the cause on each line.						Approximate					
-	Trysician/		Approximate Intervented Hisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or least failure. List only one cause on each line. Approximate Interval Between Onset and Death Hisease or condition a. Due to (or as a consequence of):												
لحمي	Medical Examiner		Sequentially list conditions b. Cardiony o patty (EF320) 14 car												
	DIE	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b Due to (or as a co	onsequence of):	i crity o pa	11901	32	10)	1 year					
0.	uted rd ansit	Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events	c											
) P	e exectian ar	al Ex	resulting in death) Last	Due to (or as a co	onsequence of):										
200	rath certificate be executed attending physician and for use as the burial-transit	Medical	_	d	-										
687	certific nding Ise as	Ž.	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of					23d. Date of de	alivan					
30 X	leath (e atter d for u	icia	in the past 12 months? 1 Yes 2 No	1 Live Birth 2 4 Pregnant at tir		Ectopic pregnancy Other (specify)			Month Month	Day Year					
P.O. Box 68760	t the c by th	Physician/N	9 Unknown	9 Unknown											
<u>. </u>	es tha signed be de	2	Part II. Other significant conditions con	itributing to death but i	not resulting in the u	nderlying cause give	en in Part I.		bacco use contribute t						
ıds	requir been s should	letec	LITA/					-		Probably 4 Unknown					
ecc	sician: The law certificate has b lirector, page 2 s	Completed	[[] [V					24a. Was a autops perfor	med? prior to death?	utopsy findings available completion of cause of					
<u>س</u>	an: Th tificate tor, pa		25. Was case referred to medical			26. Pla	ce of Death (Check	1 🗆 Yes	2 No 1 ☐ Ye	es 2 🗆 No					
Vit.	ysicia iis cer direct	10 B	examiner? 1 Yes 2 No	lospital: 1	2 ER/Outpatien	Other			ence 6 🗆 Other (Spe	cify)					
o	ing Pt		27. Manner Death 1 atural 5 ☐ Pending	28a. Date of injury (Month, Day, Ye	28b. Time of injury	28c. Injury work?	at 2		w injury occurred	,					
sion	ttend death stor: A / the f	Certificate:	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be	20 a Disea of Injury	At home from atom		fes 2 ☐ No								
Division of Vital Records,	al or A safter I Direct d in by		4 Homicide determined	building, etc. (S	- At home, farm, stre Spec <i>ify)</i>	eet, ractory, office		28f. Location (St City or Town	reet and Number or Ro n, State)	ural Route Number,					
7	ospite hours uneral	Medical	29a. Certifier 1 Certifying Physi	cian: To the best of my	knowledge, death o	occured at the time,	date and place, and	d due to the cau	se(s) and manner as st	ated.					
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit		only one) 3 L Certifying Nurse	er: On the basis of exan Practioner: To the bes	rimation and/or invest st of my knowledge, d	leath occurred at the	time, date and place	tne time, date an e, and due to the	d place, and due to the cause(s) and manner as	cause(s) and manner stated.					
	5 ₹ ₹		29b. Signature and title of certifier	/ A1. A		29c. License	number 57021	2	9d. Date signed (Mont						
			30. Name and address of person who co	empleted cause of door	h (Item 23a) (Time P				01/14/20						
	5 ^{† '}		Rita Mathur, M.D.	9106 PA	hiladelPhi		106, Ba	14. MD	21237						
H	Stat	٠ ا	31. Date filed (Month, Day, Year)		Signature										
	Registra		JAN 2 0 20	III / Zama		RA Made									

DHMH 17 Rev 7/2009

DHMH 17 Rev 7/2009

		Please Type or Print in				•		
		State of Marylar		partment of F ertificate of I		Mental Hy	giene	20000
2 3	F	1. Decedent's Name (First, Middle, Last)		eruncate of i	Death	2. Date of De	Reg. No.	3, Time of Death
Physicia		Grorge Colbe	ty			Month	9 201	7;00 ам
/Medic Examin		4a. Facility Name (If not institution, give street and number)	, 4	4b. City, Town, or	r Location of Dea	th	4c. County of De	eath
	a.	1512 Taylor Avenue	1 6 to 1	Parkv	ille If Under 24 Hrs	Detect Die	Balt	
Funeral Director		5. Social Security Number 6. Sex 7. Age (<i>In yrs.</i> 1979 1979 1979 1979 1979 1979 1979 197	. last birthda Yrs.	Months Days	Hours Min		y, Year)	lirthplace (State or Foreign Country) MD
D		Usual Residence of Decedent				12-1	1340	
arylan show d at	_	MD D 11	ity, Town or					10d. Inside City Limits 1 ☐ Yes 2 ☐ No
filed within 72 hours after death with the Maryland Hygiene. uther than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at	Funeral Director	MD Baltimore Pa	arkvi	. 11e			10g. Citizen of What	
3a or	ä			2123	2.4		U S A	Sourity:
death	nera	1512 Taylor Avenue 11. Marital Status 12. Was Decedent Ever in U	J.S. 1:	3. Was Decedent of H		Specify Yes or No		nerican Indian,
after or ite		1 Never Married 2 Married 1 Yes 2 No		1 ☐ Yes 2 🖾 No	Specify:	nto rilicani, etc.)		Black
hours tural"; al Exa	ed by	3 ☐ Widowed 4 ⚠️Divorced Year or Dates:	16a De	cedent's Usual Occup	ation		16b. Kind of Busines	
in 72 n "na"	plete	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Gi	ve kind of work done of the contract of the co	during most of wo	orking	Baltimo	
d with giene er tha	Completed	10th grade na		Superviso	r		Dept of	Public Work
be file d oth event	Be	17. Father's Name (First, Middle, Last) Robert Lloyd Colbert, Sr		_		me (First, Middle, Thomas	Maiden Surname)	
should be and Mental s marked c umatic ev	၉	19a. Informant's Name/Relationship (Type. Print)	19h Ma	iling Address (Street		4		, Zip CodeApt Bl
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		Chandra Colbert-daughter	1	36 N. Hil			Balto, MD	-
es 1 a of Hea Item		20a. Method of Disposition 20b.	Place of Dis	position (Name of rematory or other place	ce)	Date	20c. Location - City	
Pages ment of ant: If Its ury or o		1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	ing N	lemórial	Pk 1−2	0-2010	Randall	stown, MD
permit. Departr Imports any Inji		21. Signeture of Funeral Service Licensee		22. Name and Addre			ast F/H	
20 2 6 O		23a Part 1 Enter the disease or complications that caused the dea	ith Do not 6	1101 E.				MD 21202
Dhysisian		23a. Part1. Enter the disease, or complications that caused the dea shock, or heart failure. List only one cause on each line. Immediate Cause (Final			ig, such as cardi		11631,	Approximate Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death) a. Due to (or as a consecution product)	quence of)	MrJe	A TIL	Fase		1
Examiner		Se description for a cultimate to the Dill of	ten	Cardi	iny of ath	1/		
ed sit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	quence of):	1. 1		λ,		
xecut al-tran	Examiner	that initiated events resulting in death) Last C. Due to (or as a consec	quence of):	diav j	achyca	rong		
The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	=	d			J			
rtifical ng phy as th	Physician/Medica	IF FEMALE:						
leath certific attending pl	lan/l	23b. Was decedent pregnant 23c. If yes, outcome pf pregnant 1 □ Live birth 2 □ Fet 2 □ Fe	al death	3 ☐Ectopic pregnancy	/		23d. Date of o	delivery Day Year
at the de by the a tached f	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 4 ☐ Pregnant at time of 9 ☐ Unknown	death :	5 ☐ Other (specify) _				,
res that tigned by	y Ph	Part II. Other significant conditions contributing to death but not re-	sulting in the	underlying cause giv	en in Part I.	23e. Did t	obacco use contribute	to the cause of death?
w requires been sign should be	ed by	Heart Failure				1 🗆	Yes 2□No 3□	Probably 4XUnknown
law reas bee	Completed	Anemia				24a. Was	an 24b. Were	autopsy findings available o completion of cause of
The sate h	Com					perfo 1∐ Yes	ormed? death 2.2.No 1 ☐ Y	?
sician: The law certificate has t irector, page 2 s	Be	25. Was case referred to medical examiner? Hospital: Hospital:		iont 2 DOA Oth	05	eath (Check only o		
Physer this eral di	은	27. Manner of Death 28a. Date of Injury	28b. Time	of 28c. Injur	4 ∐ Nursing		dence 6 Other (S)	pecify)
ath. r; Afte	atior	1 ☑ Natural 5 □ Pending (Month, Day Year) 2 □ Accident investigation	Injur		ƙ? Yes 2∐No			
r Atte ler dea irecto	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of injury - At result building, etc. (Special Special	nome, farm,	street, factory, office		28f. Location (City or To	Street and Number or wn, State)	Rural Route Number,
pital o urs aff eral D	Se	Constitution of Property and Pr		ath a surround at the at-				
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director, After this certifica completely filled in by the funeral director, p.	Medical	29a. Certifier (Check only one) 1	ation and/or	Investigation, in my o	me, date and place opinion, death oc	ce, and due to the curred at the time,	date and place, and c	as stated. lue to the cause(s)
To the To the To the Complex c	Me	29b. Signature and title oncertifier	Λ . Λ	29c. Licens	e number		29d. Date signed (Mo	nth, Day, Year)
		· /// Tun 1	MI)	1 1 5	7148		January 1	8,2010
Ц		30. Name and address of person who completed cause of death (Ite			MA		-/	,
Sta	te.	21 Data filed (Month Day, Voor) 32 Bentstrar's Sign	aturo	examifl Di	IND <	21217		
Registr		JAN 2 0 2010 Senter J.	back					
HMH 17 Rev 1/20	01							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 00900 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death **Physician** Month Willah Jane Christner 1/19/2010 8:15 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Carrol1 Carroll Hospital Center Westminster 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 8/8/1941 9. Birthplace (State or Foreign Months Days Hours Min. OH 68 277-36-6226 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2X No MD Carrol1 Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2201 Brightspot Dr. 21157 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 Yes XXNo Specify. þ Specify: 3℃Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Data Processor **AFSCME** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frances Strasel ပ Lennis F Vallance 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mark Allen Christner/Son 2201 Brightspot Dr., Westminster, MD 21157 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Carroll Crem. 1/20/2010 Winfield, MD 21. Signature of Funeral Se ²² Name and Address of Facility Burrier-Queen Funeral Home & Crematory, P.A. 1212 W. Old Liberty Rd., Winfield, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to infinite date cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence or) Due to (or as a consequence of). Physician/Medical IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ZNo Month Day Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of eause of death? 24a. Was an perform 2 No 2 **N**0 1 □ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗖 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 27. Manne of Death 5 Pending investigation

Examiner The law requires that the death certificate be executed and Box 68760; physician the attending asn for P.O. the ģ signed be det Division of Vital Records, peen has page 2 certificate Hospital or Attending Physician;

Funeral

Director

28a-f show

ir than "natural", or items 23a or 28a-f show

death with the Maryland

Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.

and Mental Hygiene.

permit. Pages 1 and 2 should be Department of Health and Menta Important; If Item 27 is marked any Injury or other traumatic ev

Physician /Medical

Baltimore, Maryland 21215-0036

28a. Date of Injury (Month, Day, Year) 28b. Time of

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 PCCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date/signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6 Could not be determined

State Registrar

31. Date filed (Month, Day, Year)

1 Natural

2 Accident

3 Suicide

4 ☐ Homicide

32. Registrar's Signature

after death Director; / d in by the f

within 24 hours after To the Funeral Discompletely filled in

To the I

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month M. Calloway Anna 6:48PM Januarv 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Washington Adventist Hospital Takoma Park Montgomery 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign July 6 Gountry)
North 1 □ M 2 🛛 F Hours Min 245-26-1895 87 Director Carolina Usual Residence of Decedent show ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits DC 1 X Yes 2 ☐ No Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1730 7th Street, N.W. 20002 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 XNo Black, White, etc. 1 Never Married 2 Married Completed by 72 hours after Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates 3 XWidowed 4 ☐ Divorced Specify Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Waitress Private Be Department of Health and Mental H Important if frem 27 is marked oft any injury or other traumatic 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Charlie Little Ruth Beattie 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20772 Anna M. Hunter/Granddaught¢r 7305 Georgia Drive, Upper Marlboro, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Harmony Mem. Park 1/16/10 Landover, MD 22. Name and Address of Facility Austin Royster Funeral Home Signature of Funeral Service Licensee M00996 3821 14th Street, NW, Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ neumon disease or condition / Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine if any, Isading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a consequence on Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

24 hours after death.

Funeral Director. After this certificate has been signed by the attending physician and eled filled in by the funeral director, page 2 should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) Day Month Year 9 Unknown g Unknown ate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 2 🔀 No Other: မ 1 🗌 Yes 1 Npatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred X Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🙎 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in this opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

State Registrar

DHMH 17 Rev 7/2009

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

ess of person who completed cause of

eath (Item 23a) (Type, Print)

CAN

29c. License number

(N, 124

amend #8,11 date look land be per ANA BP 6899 and Remail Hyglene amend items 20a-c,22 per fh 8899 1-27-10 yt

Certificate of Death

Reg. No. Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ chavis Month Deborah T:35 AM Medical Januam 2010 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Bayview Medical Baltimore Johns Conto Hopkins Social Security Number 6. Sex Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral 9. Birthplace (State or Foreign 1 □ M 2 🏋 F North Carolina Months Days Hours Min. Month Day, Ye Aug 24, **Director** 020-52-2028 T956 Usual Residence of Decedent or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important! If tiem 27 is anarked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD Baltimore 1 Yes 2 I No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21206 USA 4715 Hazelwood Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force 1 XX ever Married 2 Married Black, White, etc. Completed by ☐ Yes 2 X No Baltimore, Maryland 21215-0036 Specify: black 3 ☐ Widowed 4 ☐ Divorced If Yes, Give 1 ☐ Yes 2 X No Specify: Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education unk unk 16b. Kind of Business Industry (Specify only highest grade completed) unk Elementary/Seconday (0-12) College (1-4 or 5+) Security Guard Be 17. Father's Name (First, Middle, Last) unk unk 18. Mother's Name (First, Middle, Maiden Sumame) Jarvis Chavis Elnora Williams 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4940 Eastern Avenue Baltimore, MD Bayview Medical Center 4715 Haxelwood Avenue Baltomore, MD 21206
e of Disposition (Name of Date 20c. Location - City or Town, State Deadra Chavis/ daughter 20b. Place of Disposition (Name of Page 1 1 Burial 2 X Cremation 3 Removal from State matory or other place)
rown FH & Joseph Brown 1-22-10 4 ☐ Donation 5 😾 🗪 Baltimore, Md. Crematory . Signature Funeral Service Joseph H. Brown Jr. FH Name and A, dress of Facility Street 2140 N. Fulton Ave in Enter the disease, or compli ications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock or heart failure. List only one cause on each line Interval Betweer Immediate Cause (Final Onset and Death Ph_sician/ Peritonitis disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner carcinoma tosis unknown pentoneal Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day 5 Other (specify) Pregnant at time of death Month Year io une runeral ulrector. After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached 9 Unknown 9 Unknown P.0 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred 1 🔀 Natural injury 5 Pending death Accident Suicide Investigation within 24 hours after deat To the Funeral Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES - 000 2010 5 Junuam 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bultimore 21224 Nanon 4940 Eastern Avenue MD 31. Date filed (Mont) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - State of Maryland / Department of Health and Mental Hygiene 23aPt1, II per dr. 2900, 02/09/2010dhb Registrar Reg. Na 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** Month JAMES CORBIN 2010 1:40 AM January 10 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE WASHINGTON MEDICAL CENTER ARUNDEL GLEN BURNIE ANNE 5. Social Security Number If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Oct 22, 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** ^{Year)} 1945 Months 1 M 2 □ F Virginia 215-44-3369 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f shore Examiner must be notified at 1 ☐ Yes 2√ No Director MD Anne Arundel Hanover 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 Chesapeake Mobile Court 21076 USA permit. Pages 1 and 2 should be filed within 72 hours after death N Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23: any injury or other traumatic event, the Medical Examir or must any injury or other traumatic event, the Medical Examir or must Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 Divorced white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 0 handyman various 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Wilfred Aloyuius Corbin ၉ Lena Wright 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Baltimore Washington Medical Ctr 301 Hospital Drive Glen Burnie, MD 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify) 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street 21. Signature Funeral Service Baltimore, MD _21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. **Cardiogenic Shock** Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) CARDIO KESTIRATOR) /Medical Due to (or as a consequence of): Septicemia Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or) Examine Pneumonia After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by Congestive Heart (ailwice 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Chronic Obstructive Pulmonary Disease 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autonsy performed Vital 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 10 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To ð 27, Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 ☐ Pending investigation To the Hospital or Attendir within 24 hours after death. To the Funeral Director: At completely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of gertifier 29c. License number 29d. Date signed (Month, Day, Year) , MD DO63564 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kalpech Patel Baltimore Washington Medical Center 301 Hospital 5 Patel Kalpesh 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JAN 20 2010 Registrar

DHMH 17 Rev 1/2001

CORBIN, JAMES

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 02:07 PM James Cunningham 02 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE AGNES HOSPITAL If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 6. Sex 9. Birthplace (State or Foreign Country) **Funeral** Hours unk 1 ▼ M 2 □ F 80 Director 578-36-9483 NOv 9, 1929 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show s 1 and 2 should be filed within 72 hours after death with the Maryla of Health and Mental Hygiene. It has a state of the Agrae of Sea-f show other traumatic event, It will Medical Froming must be realised at 1 ☐ Yes 2 ☐ No Director MD Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21229 701 Edmondson Avenue USA 12. Was Decedent Ever in U.S. Armed Forces? unk Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 🛛 No Specify: Specify: black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) æ unk unk ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 900 S. Caton Avenue Baltimore, MD St. Agnes Hospital 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages 1
Department of Hi
Important: If iter
any injury or oth 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 5 Hother (specify) to stake 4 ☐ Donation 21. Signa In of Funeral Sepring Sicensee de State Anatomy Board 655 W. Baltimroe Street Baltimore,MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or complition) Approximate Interval Between Onset and Death Shock **Physician** 13 days disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner piration Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Parkinsons Due to (or as a consequence of) the attending physician thed for use as the buria P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) □Yes 2□No detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 3 Probably 4 ☑ Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an has autopsy performed? To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, page Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28c. Injury at Work? 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 1 📉 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Mahmoind Aldandashi Jan, 02, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Mahmoud Aldandashi, 900 Caton Ave, Baltimore 32 Registrar's Signature 31. Date filed (Month, Day, Year) State JAN 20 2010 Cerus Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 0905 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 3:04 P.^M Phyllis Elva Carrick /Medical January 18. 2010 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Upper Chesapeake Medical Center Bel Air Harford If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 🛛 F Director 218-18-8315 84 Mar. 9, 1925 Maryland Usual Residence of Decedent death with the Maryland 10a, State 10h County 10c. City. Town or Location 10d. Inside City Limits Important; If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, Its Modical Examinations is use by natified at 1 ☐ Yes 21 No Directo Maryland Harford Havre de Grace 10e. Street and Number 10g. Citizen of What Country? 203 Secretariat Drive, Unit C 21078 Funeral USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 No Specify ≥ Specify 3√2 Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within: Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) Assembly Line Worker Soap Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Grover (nmn) Griffith ഉ Lyndall (nmn) Street 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) H. John Blische / Son 203 Secretariat Dr. Unit C, Havre de Grace, MD 21078 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Dak Lawn Cemetery 1/21/2010 Baltimore, Maryland 22. Name and Address of Facility McComas Funeral Home, P.A. Signature of Funeral Service Licensee 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) a.cdiac /Medical Due to (or as a consequence of): Examiner OP 1) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) herosclerosis probable Due to (or as a consequence of) attending physician for use as the burial The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No
9 Unknown 23d Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) #he 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 1 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? (es 2 No certificate Division of Vital 1 ☐ Yes Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 □ No 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA မ 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death e Funeral Director: 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) ca (Check only one) and manner stated. within 2 To the the 29b. Signature and little of certifier 29d. Date signed (Month, Day, Year) ompleted cause of death (Item 23a) (Type, Print) 30. Name and ad ress of person pper Chesapeake Dr. Bel Air, M. State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death CARTWRIGHT EARL **Physician** 18 ,26 pm 20/0 raman /Medical la. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death ef.Death Examiner sons 7 11/15/4 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Pay, Year) Birthplace (State or Foreign Country) Age (In yrs. last birthday) Social Security Number 6. Sex **Funeral** 6059 Months Min. Days 1 □ M 2 🔽 Hours Yrs Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental Hygiene. nt: If item 27 is marked other than "natural", or items 23a or 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show ediest Exarting at 1 Yes 2 No Directo more 10f. Zip Code 10g. Citizen of What Country? Street and Number INO Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 ∐Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Neyer Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ Wo Specify: ģ 3 Nidowed 4 □ Divorced Completed 7 is marked other than "natu traumatic event, the Medical Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) etheram 17. Father's Name (First, Middle, Last) Be ပ္ 19b. Mailing Address (Street and Number Thornton - daughte permit. Pages 1 and:
Department of Health
Important: If item 27
any Injury or other tr Donita 20b. Place of Disposition (Name of gemetery, crematory or other place) 20a. Method of Disposition ocation - Çity or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State altimore. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature Funeral Service License Hoxue 10er to 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line. Immediate Cause (Final BREAST Physician CARCISTOMA OF ETASTATIC disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) The law requires that the death certificate be executed attending physician and for use as the burial-trai Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ PULMOMARY EMBOLISM MONIA 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? certificate has b irector, page 2 sh 24a. Was an autopsy perform 2 No 1 □ Yes 2 **X**No To the Hospital or Attending Physician: filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 🗆 No within 24 hours after deatl To the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D54288 2010

State Registrar

DHMH 17 Rev 1/2001

MMASH

31. Date filed (Month, Day, Year)

ORIGINAL

RANGARAJAN

Registrar's Signature

MORTHWEST

HOSPMAZ

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Anu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ TANUARY 2010 5:00 AM Medical Rosalie Irene Dooley 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Anne Arundel Glen Burnie Baltimore Washington Medical Center 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** ^{Year)} 1929 Davs (Month, Day, April 25. 1 M 2 XX **Director** 217-24-4898 80 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 28a-f 1 Yes 2 No Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 192 Plymouth La Apt B 21061 USA filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, þ 1 Never Married 2XX Married 1 ☐ Yes 2X X No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2XX No Specify: Specify: Completed 3 Widowed 4 Divorced White Year or Dates Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Waitress Restaurant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Charles William Ricker Martha Hoffman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Gilbert Dooley 192 Plymouth La Apt B, Glen Burnie, MD 21061 Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 Burial 2 XXCremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Jan 27, 2010 Glen Haven Çemetery Glen Burnie, MD 21. Signature of Funeral Service Lie Name and Address of Facility
Fink Funeral Home, P.A. Gregory 426 Crain Hwy S., Glen Burnie, MD 21061 23a. Part Enter the discase, shock, in heart failure List plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Ca. (Final disease or condition resulting in death) Onset and Death CARDIOMY OPATHY Physician/ ISCHEMIC Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examine Due to (or as a consequence of): Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) 1 ☐ Live Birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 9 ☐ Unknown in the past 12 months?
1 Yes 2 No Month signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown completed filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy Director: After this certificate 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 No Other: မ 1 Inpatient 2 PER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending within 24 hours after death. To the Funeral Director: After 1 Natural work? 1 ☐ Yes 2 ☐ No injury 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29c. License number JANUARY 19, 2010 1)31136 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

Min

9005 KICBRIDE RDY

BALTIMORE, Mi) 21236

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 14 Month Physician/ enna 10:00AM Januas 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 12 Center N/A Medical Boyview altimore Hookins If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral (Month, Day, 1 ☐ M 2 🗓 F Months Days Hours Min 218-42-5007 Maryland Director 1944 Usual Residence of Decedent or 28a-f show 10a. State 10c. City. Town or Location 10d. Inside City Limits Examiner must be notified at Director Edgemere 1 Yes 2XXNo Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 2418 Oak Manor Road United States 21219 death v 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces Black, White, etc. "natural", or 1 Never Married 2 Married 1 Yes ZXXNo
If Yes, Give
Year or Dates. Completed by iled within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3X Widowed 4 □ Divorced White event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than " any injury or other traumatic event, the Men Elementary/Seconday (0-12) College (1-4 or 5+) Law Offices Office Manager 12 Years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Monta M. Martin Donald F. Cross 19a. Informant's Name/Relationship (Type, Print) Sister 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Rhonda A. Naughton Middle River, MD 21220 Cove Court 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🖾 Burial 2 🗌 Cremation 3 🗌 Removal from State 1/18/2010 Bel Air, Maryland Bel Air Mem. Gdns. 4 Donation 5 Other (Specify) ture of Funeral Service Licensee Budge and ckss rifferal Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 23a Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Multiple Medical Due to (or a a consequence of): Examiner Sequentially list conditions, Examine (or as a consequence of): If any, leading to immedicause. Enter Underlying physician and s the burial-transit Cause (Disease or iinjury that initiated events Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending ph IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Voar Day Pregnant at time of death Ves 2 No ed by the a 9 Unknown 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Jas autopsy certificate has irector, page 2 death? 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 No 1 Yes ၉ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this c 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Matural Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending injury work?
1 ☐ Yes 2 ☐ No 5 Pending within 24 hours after death.

To the Funeral Director: A completed filled in by the fu Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier ND 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore MD M.D. 4940 Eastern Avenue Margaret M. Hayes 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		For 1 _ State	State of	of Maryla	•			d Mental Hy	/giene		
		Registrar	4 1)		Cer	tificate of I	Death		Reg. No.2		00909
Physicia	ın/	Decedent's Name (First, Middle		_				2. Date of De _Month	Day	Year	3. Time of Death
Medic		4a. Facility Name (if not institution	Anthony	J.	Deli	nski		Janua	_	2010	18:40 P [™]
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Funeral		5. Social Security Number	6. Sex	7. Age (In yr	s. last birthday)	If Under 1 Year	If Under 24 H	rs. 8. Date of Bi	rth	9. Birthp	lace (State or Foreign
Director		220-14-8680	1 X M 2 □ F	85	Yrs.	Months Days	Hours Mi	(ay, Year) 3 - 1925	Count	imore, MD
d iow	_ [Usual Residence of Decedent 10a, State 10b, County		100	City, Town or Lo	nation				1	0d. Inside City Limits
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with the 23a c	Funeral	7206 Gough	Street			2122	4		United		
eath tems er mu	Ē	11. Marital Status	12, Was Dece		U.S. 13.	Was Decedent of H	lispanic Origin?	(Specify Yes or No-		ace - Americ	
fter d ', or i	þ	1 Never Married 2 Mar	If Voc Giv	2 🗆 No		f Yes, specify Cuba I ☐ Yes 2X No		erto Rican, etc.)		ack, White, e	etc.
5-UU36 2 hours after "natural", o edical Exam	ted	3 ☑ Widowed 4 ☐ Divorced	Year or D	ates.					Specia	ry:	
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filled v	Be	17. Father's Name (First, Middle, I	.ast)			aper viso.		Name (First, Middle			
Viand Id be filed Mental Hy arked ott	일	Peter Deli	nski				Hele	en M. Kus	ka		
Mar 2 shoul th and 27 is m traum:		19a. Informant's Name/Relations						Rural Route Numbe			
e, R and 2 Health em 27 ther t		Mrs. Maureen P	iccione (Daught		06 Gough	Street		1		21224
5 - 5 E C		20a. Method of Disposition 1 🖾 Burial 2 🗆 Cremation		State		natory`or other pla		Date	20c. Location	-	·
Baltimo permit. Page 1 Department of Important: If i any Injury or o		Donation 5 Other (S		S				1/18/20			Maryland
Departition of the control of the co	1	21. Signature of Funeral Service I	acerisee (60	Ď	uda-Ruck	Funeral	l Home of	Dundal	k, Ind	222
		23a. Part 1. Enter the disease, or			Approximate Interval Between						
shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Carona Heart Dulle											
Medical Examiner		resulting in death)	a. Due to	(or as a cons	equence of):	J					
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sit ad	min	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Due to	(or as a cohs	equence of)	n,	أر مرا				i
xecute al-tran	Examiner	that initiated events resulting in death) Last	c. Due to	(or as a cons	quence of):	- 100	aber	9	<u> </u>		
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	dical		L d								
ertificate ertificate ding phy se as th	Med	IF FEMALE;									
h cert tendir r use	sician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, out			Ectopic pregnan	су			ate of delive	·
box death the atter hed for t	ysic	1 Yes 2 No	4 ☐ Preg 9 ☐ Unki	nant at time o nown	of death 5	Other (specify) _			N	lonth	Day Year
and the	/ Phy	Part II. Other significant condition	ons contributing to d	leath but not	resulting in the u	nderlying cause gi	ven in Part I.	23e. Did 1	obacco use cor	ntribute to th	e cause of death?
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The law requires the law been signate has been signate has been signaled.	Completed					_			ormed?	death?	npletion of cause of
an: The an: The tiffical tor, p	ادةا	25. Was case referred to medical				26. P	lace of Death (CI		2 % No	1 🗌 Yes	2 🗆 140
VILAI nysician: nis certific director,	To B	examiner? 1 Yes 2 No	Hospital:	Inpatient 2	☐ ER/Outpatien	t 3 DOA Oth	er: 4 Nursing	Home 5X Resi	dence 6 🗆 Ot	her (Specify)	
ing Pl		27. Manner of Death 1 ☎ Natural 5 ☐ Pendir	28a. Date (Mon	of injury th, Day, Year)	28b. Time of injury	work	₹?	28d. Describe	how injury occu	rred	
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al or Attendin s after death. I Director: Aff	Cerl	4 Homicide determ	28e. Place	of Injury - At ng, etc. (Spec	nome, farm, stre cify)	eet, factory, office		28f. Location (City or Tov	Street and Num vn, State)	ber or Rurai	Route Number,
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ne Ho in 24 t ne Fui pletec	Medical	(Check 2 Medical E	xaminer: On the bas Nurse Practioner:	sis of examina	tion and/or invest	igation, in my opini	on, death occurre	ed at the time, date	and place, and d	ue to the cau	se(s) and manner stated.
To the contract of the contrac		29b. Signature and title of certifier	11 6-	77	0 115	29c. Licens	e number		29d. Date sign	ed (Month, D	Pay, Year)
		* Theldon	4.601	(m	wy	DU		<u></u>	Januar	•	
5t1		30. Name and address of person		,	em 23a) (Type, P	,	Hopkins Eastern	s Bayviev	Medica Altimore		
Sta		Sheldon Got 31. Date filed (Month, Day, Year)		egistrar's Sig	nature_	4940	rastern	Ave. Da	TTHOTE	, PICI	Z1 Z Z Y
Registra		JAN 20	2010 /	area a	1 16	and !					

DHMH 17 Rev 7/2009

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician 17 Mary-Evelyn Delhamer January /Medical 4e. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Svkesville Fairhaven 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 5, 192 **Funeral** Months Days Hours 1 □ M 2 👿 F 218-32-0750 88 Yrs Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ihe Medical Exeminer must be nothing at any injury or other traumatic event, Ihe Medical Exeminer must be nothing at 10c. City, Town or Location 10a. State 10b. County Carroll Sykesville MD **Funeral Director** 10f. Zip Code 10e. Street and Number 21784 **USA** 7200 Third Avenue 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐Yes 2 No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No ģ 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) registered nurse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hilda Mae Russell Walter Thomas Greenwalt ဨ 19a. Informant's Name/Relationship (Type. Print) 7200 Third Ave., Sykesville, MD 21784 Robert W. Delhamer (spouse) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) All County Cremation 1-18-10 21. Signature of Funeral Service Licenses Parge Harght Herbert P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Oldvaneo dementa Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner brokury Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, Physician/Medical

2010 11:15a 4c. County of Death Carroll Birthplace (State or Foreign Country) MD 10d. Inside City Limits 1 ☐ Yes 2 No 10g. Citizen of What Country? 14. Race - American Indian, Black, White, etc. Specify: white 16b. Kind of Business/Industry health care 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20c. Location - City or Town, State Sykesville, MD 22. Name and Address of Facility Haight Funeral Home & Chapel 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant et time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Year Day 5 ☐ Other (specify) Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performer res 2 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eldersburg, MD 32 Registrar's Signature 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

State Registrar

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Division of Vital Records, P.O.

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Certification: To

Medical

DHMH 17 Rev 1/2001

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within 24 hours a

To the Funeral C

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Barbara Roseanne Dowe11 2010 10:20a January 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Carrol1 Svkesville 418 Obrecht Road Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Jan 9 5. Social Security Number 7. Age (In vrs. last birthday) Days Hours 1 □ M 2 □ F Jan 1943 NY 128-32-8721 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 □Yes 2 No Carroll Sykesville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21784 418 Obrecht Road 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 □Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 📉 No Specify: white Specify: 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Avon district sales manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Bakay Elizabeth Melder Stephen J. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 418 Obrecht Rd., Sykesville, MD 21784 Mr. George Dowell (spouse) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Owings Mills, MD Garrison Forest Vet. 1/25/10 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service License M00764 P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mmediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery

Physician /Medical Examiner

Department of Health a Important: If item 27 is any injury or other tra

Physician

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MD

Director

Funeral

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Examiner

Funeral

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d other than "natural", or items 23a or 28a-f show event, the Madical Examinar must be notified at

and Mental Hygiene.

Health a

Pages 1

and 2 should be filed within 72 hours after death with the Maryland

Saltimore, Maryland 21215-0036

Examiner and burial-tran attending physician the as nse 9 for cate has been signed by the page 2 should be detached funeral director,

law requires that the death certificate be executed

Box 68760,

Division of Vital Records, P.O.

Physician/Medical à Completed Be Certification: To

in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)	Month Day Year									
Part II. Other significant conditio	ins contributing to death but not resulting in the underlying sadds given in the	id tobacco use contribute to the cause of death? ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown									
		utopsy prior to completion of cause of death?									
25. Was case referred to medical	26. Place of Death (Check only one)										
examiner? 1 ∐ Yes 2 X No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DCA Other: 4 Nursing Home 5 Telephone 5 Teleph	Residence 6 Other (Specify)									
27. Manner of Death 1 Natural 5 Pending 2 Accident investig	(Month, Day, Year) Injury Work?	be how injury occurred									
3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ		on (Street and Number or Rural Route Number, Town, State)									
29a. Certifier 1 Certifyin (Check only one)	g Physician: To the best of my knowledge, death occurred at the time, date and place, and due to Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, and manner stated.	the cause(s) and manner as stated. me, date and place, and due to the cause(s)									

29c. License number

Columbia Miscylano

29d. Date signed (Month, Day, Year)

16,2010

after death Director:

Hospital or within 24 hours a

To the Funeral C

Registrar

Medical

29b. Signature and title of certifier

30. Name and address of person who complet

			For State Registrar	State of Ma		oartment o e <i>rtificate o</i>			Mental Hy	giene Reg. No.	2010	00912
			Decedent's Name (First, Middle, Last	*)					2. Date of De	ath		3. Time of Death
	Physicia Medic		RANSOM J. DAVIS						JAN.	15	2010	3:30P ^M
	Examin		4a. Facility Name (if not institution, give : FUTURE CARE	street and number)			vn, or Locat .TIMOR	ion of Death E			County of Death	CITY
	Funeral Director			X M 2 □ F 67	(In yrs. last birthday Yrs.		ear If Un ays Hou	nder 24 Hrs. Irs Min.	8. Date of Bir (Month, Da May 4,	th 1942	g. Birth MICH.	place (State or Foreign Try) LGAN
	nd how at	,	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or I	ocation			-	_		10d. Inside City Limits
	larylar 3a-f sl iified	Funeral Director	Maryland Baltimore			timore	City					tXX Yes 2 ☐ No
	the M	Ε	10e. Street and Number			10f. Zip Co				10g. Citize	en of What Cou	ntry?
	n with	nera	2404 Everton Rd.			2	1209			USA	4	
	r item iner n		11. Marital Status	12. Was Decedent Ev Armed Forces?		. Was Decedent If Yes, specify (of Hispanic Cuban, Mex	Origin? (Specican, Puerto	ecify Yes or No- Rican, etc.)	14	1. Race - Americ Black, White,	
21215-0036	safter ral", o Exam	ed by	1 ☐ Never Married 2 🛛 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes ﴾ √ N If Yes, Give Year or Dates.	0	1 🗆 Yes 2 🏿	No Spe	cify:		Sp		hite
5-0	hour natu	plete	15. Decedent's Ed (Specify only highest grad			edent's Usual O		most of work	ina	16b. Kind	d of Business In	dustry
121	thin 73	Be Completed	Elementary/Seconday (0-12) 12 yrs.	College (1-4 or 5+) life.	DO NOT use ret	ired)		g	Soli	f~Emplo	wed
d 2	lled wi I Hygid other rent, ti	Be (17. Father's Name (First, Middle, Last)	/ y15	AU	corney	18. M	other's Nam	e (First, Middle,		•	yeu
ylar	ld be f Menta arked atic ev	일	George Charles Da	vis			R	osella	Marie	Prowd	dley	
Maryland	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship (Ty) Katherine T. Davi			iling Address (St.						Code)
ore,	of Head fitem		20a. Method of Disposition		20b. Place of Dis		f	7	Date		ation - City or To	own, State
Baltimore,	Page tment tant: I		1 Burial 2 Cremation 3	Hemoval from State	Bohemiar			1~20	2010	Balti	imore,	Maryland
Bal	permit Depar Impor any in		21. Signature of Funeral Service License	the Co		22. Name and A Lassahn	ddress of Fa Fune	ral Ho	\mo		lair Rd re, Md.	
П			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only on	or respiratory ar	rest,		Approximate Interval Between					
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6876	ificate I ng phys as the	ı wı	IF FEMALE:	•								
9 X	ath certifica attending p	ian/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of Live Birth 2	Fetal death 3					23	ld. Date of deliv	ery Day Year
. Box	he dea y the a ched fi	nysic	1 Yes 2 No 9 Unknown	4 ☐ Pregnant at t 9 ☐ Unknown	ime of death 5	Other (specif	у)				MOTH	Day real
, P.O.	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Completed by Physician/M	Part II. Other significant conditions co	ntributing to death but	not resulting in the	underlying caus	e given in F	Part I.				he cause of death?
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al F	Physician: The lav r this certificate has aral director, page 2	Be C	25. Was case referred to fiedical examiner?			2	6. Place of I	Death (Chee	1 🗌 Yes Tonly one)	2 Lino	1 🗆 Yes	2 L No
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Division of Vital Records,	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral	Certificate:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day,	Year) 28b. Time injury	200.	Injury at work? 1 □ Yes 2		28d. Describe h	now injury o	ccurred	
ivisid	or Atte	Sertif	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury building, etc.	r - At home, farm, s (Specify)	treet, factory, off	ice		28f. Location (S City or Tow		lumber or Rura	l Route Number,
	bspital hours a uneral L	Medical (29a. Certifier 1 Certifying Physi	cian. To the best of m	y knowledge, deatl	occured at the	time, date a	and place, an	d due to the ca	use(s) and r	manner as state	ed.
	the H thin 24 the Fu	Mec	only one) 3 L Certifying Nurse	Practioner: To the be	est of my knowledge	, death occurred	at the time,	date and plac	the time, date a e, and due to th	e cause(s) a	nd manner as st	
	5.≱ 6 8		29b. Signature and title of certifier	//_	1/10-	290. Lid	ense numb	1/7	0	29d. Date s	signed (Month,	∪ay, Year)
	6V		30. Name and address of person who co	ompleted cause of dea	th (Item 23a) (Type	Print)	1000	100	4	c, ,	11/10	1 4
	7		31 Date filled (Month Day Year)	M S2. Registrar's	D. O.	301 5+	, Pau	11/14	e Su	(to 4	09 Bal	Amery, MA
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend 20b, per Fh G900 2/5/10 TT State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Physician/ Nannie Lois Davis 10:05 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 512 N. Patterson Park Avenue Balto Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 TF Days Hours Min. (Month, Day, 8 - 2.4 -Months Director 219-38-3886 70 939 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must he matter at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD na Baltimore Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 512 N. Patterson Park Avenue 21205 U S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. ò 1 Never Married 2 Married 1 Yes 2 No If Yes, Give XX Year or Dates. Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black 3 Widowed 4 K Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) J. H. H. Elementary/Seconday (0-12) College (1-4 or 5+) Nurse Techician <u>12th grade</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Herbert Buster Mattie Link 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karen Mott-daughter 4406 Chalet Ct Apt 1 c Balto, MD 21206 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Ostanislaus Cemery 1-16-10 BALTO, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March East F/H 1101 E.North Avenue Balto, MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition UMODO Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): the attending physician and hed for use as the burial-transit POUTS 1660 C that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ ate has been signed by the atterpage 2 should be detached for u in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 autopsy perform To the Hospital or Attending Physician: The I within 24 hours after death.

To the Funeral Director: After this continued. rmed? 2 X No To the Funeral Director; After this certificate I completed filled in by the funeral director, page 1 Yes 2 No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2X No Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 X Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 🙎 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) Sanuary 15, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Zoyvia Civele 505 15 Covac nonghill My Baltimore 31. Date filed (Month, Day

DHMH 17 Rev 7/2009

State

Registrar

JAN 20 2010

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 7:50 a.M Harine lanuary 2010 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death The Johns Hopkins Hospital **Baltimore City** 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Months Days Hours 58 217-54-2201 9-20-1951 MD Usual Residence of Decedent 10c, City, Town or Location 10d. Inside City Limits 10b. County 1 X Yes 2 □ No N/A Baltimore 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 2420 E. Biddle Street 21213 S Α 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 3 Widowed 4 Divorced 2 X No Yes 1 ☐ Yes 2X No If Yes, Give Black Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Disabled <u>llth grade</u> Disabled 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Davis Queen Hamlet 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronald Davis-Brother Nancy Ct Rosedale, MD 21237 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1-16-2010 Randallstown, MD King Memorial Pk 4 Donation 5 Other (Specify) 21. Signature of Fundal Service Licenses 22. Name and Address of Facility March East F/H manh Mila 1101 E. North Avenue Balto, MD21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Due to (or as a consequence of) Due to (or as a consequence or, Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 23d. Date of delivery Day

Physician /Medical Examiner

Department of Important: If it any injury or o

Physician

/Medical

Examiner

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MD

Funeral

Director

or 28a-f shov notified at shov

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"natural", or iten

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Pages 1 and 2 should be filed within 72 hours after or nent of Health and Mental Hygiene.
ntt: If item 27 is marked other than "natural", or ite

altimore, Maryland 21215-0036

Director

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death with the Maryland

disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner that initiated events resulting in death) Last Physician/Medical IF FEMALE 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 1 ☐ Yes 2 No 1.XInpatient 2 ER/Outpatient 3 DOA 6 Other (Specify) 27. Manner of Death 28a. Date of Injury 28b. Time of Certification: 1 Natural 5 Pending investigation (Month, Day Year) 2 Accident 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, strubuilding, etc. (Specify) determined 4 Homicide 29a. Certifier Lack the control of t 2 Medical Examiner: On the basis of examination and/or in

attending physician and I for use as the burial-transit death certificate be executed Box 68760 signed by the att P.O. Division of Vital Records, page 2 should be peen has Physician: director, filled in by the funeral After Hospital or Attending death. Director: after within 24 hours a Medical (check only one) 29b. Signature and title of certifier

Natural Accident	5 Pending investigation	(Month, Day Year)	Injury M	Work?	2 🗌 No	25d. Describe now injury occurred						
] Suicide] Homicide	6 Could not be determined	28e. Place of injury - At ho building, etc. (Specify		ory, office		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
ertifier 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.												
gnature and	title of certifier		. 2	9c. License nur	nber	29d. Date signed (Month, Day, Year)						
			mp.	RES-	Juneary 12 2010							
ne and addr	ess of person who co	mpleted cause of death (Iter	m 23a) (Type, Print)									

1 Yes

600 North Wolfe St, Baltimore, MD, 21287

2 🗌 No

State Registrar

Day, Year) 31. Date filed (Month,

32. Registrar's JAN 20 2010

2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 7 2<u>010</u> Month 7, 4:30 PM M January Bradford R. DeVos 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Baltimore Oakcrest Village Care Center Baltimore 8. Date of Birth (Month, Day, Ye June 16, If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Year) 1√ M 2 □ F Months Days Hours 213-32-4210 75 1934 Massachusetts Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2√∑ No Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8810 Walther Blvd #2406 21234 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Bace - American Indian was Decedent Evi Armed Forces? 1 ☑Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 No Specify: Specify: white 3 Widowed 4 Divorced **'**58-60 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) education college professor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mable Martha Pletincks August Henri DeVos 9b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) 8810 Walther Blvd #2406 Baltimroe, MD 21234 19a. Informant's Name/Relationship (Type. Print) Jeanne DeVos/spouse 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street 21. Signatur of Funeral Service Licensee Renate S. Wad <u>Baltimore, MĎ</u> 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Parkinsons Immediate Cause (Final Disease disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No 1 ☐ Yes No No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of Natural

Physician /Medical Examiner ne

Physician

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Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, I in Ma once.

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other traumatic event, the Medical Examiner must be notified at

filed within 72 hours after

Pages 1 and 2 should be

Baltimore, Maryland 21215-0036

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Completed by Physician/Medical

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Certification:

Medical

The law requires that the death certificate be executed

Box 68760

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or Attending Physician:

attending physician and for use as the burial-transit ned by the a cate has l page 2 s this certificate director, hours after death.

uneral Director: After the filled in by the funeral

25. Was case examiner	reterred to medical
1 ☐ Yes	
27. Manner of	Death

2 Accident

3 ☐ Suicide

4 Homicide

28a. Date of Injury (Month, Day, Year) 5 ☐ Pending investigation 6 ☐ Could not be

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 29a. Certifier (Check only one)

determined

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

29c. License number K171944

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

HAKKIYOL COM ho completed cause of death (Item 23a) (Type, Print)

Blod, Parkville, MO 21234 CRNP MON 8800 Walther 31. Date filed Registrar's Sign

State Registrar

within 24 hours a

To the Funeral C

completely filled

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2010 Joan W. Denny January 2:55 PM M Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Gilchrist Hospice Towson 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 □ M 2 😾 F Months Days Hours Min. Apr 3, 1930 Maryland Director 213-30-1596 79 Usual Residence of Decedent or 28a-f show d Hygiene. I other than "natural", or items 23a or 28a-f shovent, the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Baltimore Lutherville 10e. Street and Number 10g. Citizen of What Country? Funeral USA 101 Brightwood Club Drive 21093 within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify white Specify Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) volunteer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fishers or permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marken any injury or other traumatic eonee. Walter Lee Denny Mildred Weiskitel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Cromwell/son 1900 Highland Ridge Drive Phoenix, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 ☐ Other (Specify) of Funeral Tryice Licenses Signal ²². State Adnationly Board 655 W. Baltimore Street Director Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betweer shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ Atheroschoolic Cardiovasmlar disease or condition resulting in death) Medical Due to (or as a consequence of) Examine Sequentially list conditions, Examine Due to for as a nonsequence of It any leading to in medi-cause. Enter Underlying Cause (Disease or iinjury or Attending Physician: The law requires that the death certificate be executed the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as 23c, If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death signed by the ar Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has page 2 autopsy performed? certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 📈 No Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☑ Other (Specify) After this filled in by the funeral 27, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 24 hours after death. Funeral Director: A 1 Yes 2 No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) To the Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 7/2009

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January 11, 2010

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Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 701

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31. Date filed *(Month, D*ay, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygiene 00917 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ January 15, 2010 Robert Frederick Davis 8:00 A.M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Gilchrist Center @ GBMC Towson If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day Year Sept. 21, 5. Social Security Number 6. Sex 1 XM 2 □ F 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign **Funeral** Days Hours Director Sept. 1941 216-44-0164 66 Maryland Usual Residence of Decedent 23a or 28a-f shov 10a. State permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Important: I firem 27 is anarked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 ☐ Yes 2X No Baltimore Maryland Glen Arm 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5909 Glen Arm Road 21057 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 XNo Black, White, etc. Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes Give Specify: 3 Divorced 4 Divorced White Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Warehouse Worker Chemical Manufacturer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edgar (unk) Davis Marcella (unk) Lowery 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catherine S. Davis / Wife 5909 Glen Arm Road, Glen Arm, Maryland, 21057 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Gardens of Faith Cem. 1/20/2010 Baltimore, Maryland 21. Signature of Funeral Service Liver 22. Name and Address of Facility McComas Funeral Home, P.A. 50 W. Broadway, Bel Air, Maryland 21014 23a. Part 1. Enter the disease, or compare times that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Dulmonary Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any Irea line to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examiner Due to (or as a consumence of The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death 2 No P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by mazir - tooth Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Vunknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 A No 2 🗌 No 1 🗌 Yes ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 24 hours after death. Funeral Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred 5 Pending work' 1 Tyes Investigation 6 Could not be Accident 3 Suicide 4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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. Registrar's Signatur

58303

Charles ST TONSON

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2010 Corrado (nmn) DePinto January 11:15 P^M Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Hospice Timonium Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days July 3, 1932 1 X M 2 - F Months Hours Director 140-24-6261 77 Italy Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🔀 No Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 311 Althea Court 21015 USA 18, 2010 11:15 p.m. Maryland 21215-0036 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. þ 1 Never Married 2 X Married Yes 2 XNo If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify: Completed 3 Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Engineering Technician U.S. Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Joseph (nmn) DePinto Nicoletta (nmn) Forgia 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janet M. DePinto / Wife Althea Court, Bel Air, MD 21015 Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date X Burial 2 Cremation 3 Removal from State St. Mary's Epis. Cem. 4 Donation 5 Other (Specify) 1-23-10 Abingdon, Maryland 22. Name and Address of Facility
McComas Funeral Home, P.A.
50 W. Broadway, Bel Air, MD 21014 Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or compiliations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) LUNG CANCER Medical Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that in the leading of the leadin Due to (or as a consequence of): attending physician and for use as the burial-transil that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? è Records, Completed 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 1 ☐ Yes 2 ☐ No Yes Division of Vital 25. Was case referred to medical B B 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 🗶 No Certificate: To Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6X Other (Specify) HOSPICE 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred injury 1 🗶 Natural 5 Pending work' 1 ☐ Yes 2 ☐ No Investigation 6 Could not be ☐ Accider☐ Suicide Accident Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide City or Town, State) within 24 hours a

To the Funeral I

completed filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) 2010

Registrar DHMH 17 Rev 7/2009

State

DEPINTO

TIMONIUM,

2300 DULANEY VALLEY RD.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CRNP

JACKIE JONES,

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 🤈 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2010 Brawlev Evans Month 1 29 AM Tanua. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Good Samaritan Hospital Baltimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) SC 8. Date of Birth **Funeral** 1 **X** M 2 □ F Director 250-52-431 76 Usual Residence of Decedent or 28a-f shov notified at shov 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Director XX Yes 2 No Baltimore NA MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 27 is marked other than "natural", or items 23a or traumatic event, the Medical Examiner must be Funeral USA 21218 3812 The Alameda 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. African Completed by 1 Never Married 2 Married 2 X No Yes Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: American 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Steel Plant Co. 9th Grade Supervisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Beatrice Williams ٩ John Thomas Evans 1 and 2 should b of Health and Mer item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3812 The Alameda Baltimore, MD 21218Fannie Evans-Wife other 1 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a Department of H Important: If ite any injury or oth 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mem. Pk. Cem 01-20-10 Randallstown, 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Wylie Funeral Home P.A. Street Baltimore, MD 21217 638 N. Gilmor Street Baltimore, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Sepsis disease or condition Medical resulting in death) Due t (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events southing in death). Examiner Due to (or as a consequence of): attending physician and for use as the burial-trans Due to (or as a consequence of): resulting in death) Last Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an death? 1 ☐ Yes 2 🗹 No Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) eral Director: After this filled in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 Yes 2 No ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number determined within 24 hours after To the Funeral Direc City or Town, State Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) RES-000 01-14-2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6:00 Samprifan Hospital 5601 Lock Ravey Blud Bultimore, HD. Maroz

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. end PI line a-b, 28a, b&e per ME 8899 1/22/10 FT State of Maryland / Department of Health and Mental Hygiene For State Registrat Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 2:49 Adell M. Ernharth /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner St. Catherine's Nursing center Emmittsburg Frederick If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Days Hours Min. (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🕅 F 199-10-2513 91 Yrs 1918 Director Pennsylvanis Mar 12, Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits MD 1 ☐ Yes 2√ No Frederick Emmittsburg Funeral Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 331 S. Seton Avenue 21727 USA Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) waitress food industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Rosalia Malek Peter Synowka 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11704 Dinwiddie Drive Rockville, MD 20852 Joyce E. Johnson/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. 4 XDonation 5 ☐ Other (Specify) 21. Sign Jure J Euneral Service Licenses State Anatomy Board 655 W. Baltimore Street ade, Director 21201 Baltimore, MD . Enter the disease, or com of heart failure. List only complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of deliver 1 Live birth 2 Fetal death 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 2 X No 3 Probably 4 □Unknown 1 🗆 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical 26. Place of Death | Check only or Hospital: Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending 1 ☐ Yes 2 No investigation 2 Accident 1/2/12 100 2125 6 Could not be determined 3 Suicide 28f. Location (Steet and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At hor building, etc. (Specify) At home, farm, street, factory, office 4 - Homicide 331 South Set Ave 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001

State

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

in than "natural", or Items 23a or 28a-f show the Medical Examinar must be notified at

other than "

ages 1 and 2 should be fill on of Health and Mental Hit: If Item 27 is marked off y or other traumatic even

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after death.

within 24 hours a To the Funeral C To the Hospital

physician

Pages nent of h

or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Alan Lee Carroll 310 S. Seton Ave

2. Registrar's Signature

18705

Emmitsburg, Md 21727-0309

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death Day **Physician** Joyce V. Ebersole 1/16/2010 /Medical 3:38 Α 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 519 Manor Road Glen Burnie Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 2 / 11 / 1944 9. Birthplace (State or Foreign Country)
Maryland 5. Social Security Number 6 Sev 7. Age (In yrs. last birthday) **Funeral** Hours Days 1 □ M 2 🔀 F 65 Director 220-40-9400 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Lancers 2.1 and Mental Hygiene.
I amarked other than "natural", or items 23a or 28a-f show
"sumatic event, the the disal Examine I must be notified at **Funeral Director** 1 ☐ Yes 2 XNo MD Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 519 Manor Road 21061 USA filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ∐Yes 2**X** No If Yes, Give Year or Dates; 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Completed by 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Bar Maid Bar 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) Be and 2 should be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev Bud Wetzel Mary Gartrel ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald H. Ebersole/Husband 519 Manor Road, Glen Burnie, Maryland 21061 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State

Denation 5 ☐ Other (Specify) Bayview Crematory 1/21/2010 Baltimore, Maryland 21. Signatu e of Funeral Service Licensee 22. Name and Address of Facility Hubbard Funeral Home, Inc. 4107 WIlkens Avenue, Baltimore, Maryland 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of shock, or heart failure. List only one course on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner Sequentially list conditions, if any, leading to infine diate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine for as a consequence of Physician: The law requires that the death certificate be executed and burial-trar Box 68760, attending physician for use as the buria Physician/Medical the 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Dav Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) signed by the a P.O. 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 performed No certificate Division of Vital 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No after death Director: / d in by the f 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aft To the Funeral Di completely filled in 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) mmner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Hospital or Attending

State Registrar 31. Date filed (Month, Day, Year)

29b. Signature and title

30. Name and address of person

strar's Signature

mpleted cause of death (Item 23a) (Type, Print)

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day

4b. City, Town, or Location of Death

January

10:00 A

2010

4c. County of Death

Physician /Medical Examiner

4a. Facility Name (If not institution, give street and number)

be executed burial-tran Division of Vital Records, P.O. Box 68760 attending physician for use as the burial ed by the a detached f signed by the sign of the sign page 2 should certificate has

Johns Hopkins Bayview Medical Center HOW Pear I If Under 24 Hrs. N/A 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) If Under Birthplace (State or Foreign Country) **Funeral** Days Hours Months Min. 1 □ M 2 🖾 F 58 414-88-8210 Director 28,1951 Tennessee Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Marical Exyminal must be notified at once. 1 ☐ Yes 2 No Director Dundalk MD Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2846 Plainfield Road United States 21222 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status 1 □Yes 2)X If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 □Yes 2 No Specify: White Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Nursing Aide Healthcare Provider 12 Years 18. Mother's Name (First, Middle, Malden Surname) 17. Father's Name (First, Middle, Last) Be Dafnie Canady Carl Cox ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2846 Plainfield Road Dundalk, Maryland 21222 19a. Informant's Name/Relationship (Type. Print) Mr. John R. Franklin (Husband) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Holly Hill Mem. Gdns. 1/20/2010 Middle River, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, ture of Funeral Service Lice Inc. 21222 Re Dundalk, Maryland 7922 Wise Ave. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician System disease or condition resulting in death) /Medical Due to (or as a conseque ce of): **Examiner** oronar Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Thknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 2 No 1 ☐ Yes 2 100 funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1∐ Yes Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1. Natural To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 12certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number
PS 3 850 29d. Date signed (Month, Day, Year) 29b. Signature and the of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 Gastern Avenue, Baltimore, MD. 21224 31. Date filed (Month State 20 Registrar

DHMH 17 Rev 1/2001

Physician/ Medical Examiner

Physician/

Medical

Director

Completed by Funeral

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Examiner

Funeral

Director

or items 23a or 28a-f shov

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Be Completed by Physician/Medical Examiner within 24 hours after death

To the Funeral Director: ,
completed filled in by the

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Medical Certificate:

the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760

Out Xt		onard J. Ruck, Inc. 05 Harford Road Bal	timore Marvla	nd 21214	
23a. Part 1. Enter the disease, or complishock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)	cations that caused the death. Do not enter cause on each line.				Approximate Interval Between Onset and Death
if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last	Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):				
d					
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		Ectopic pregnancy Other (specify)		23d. Date of de Month	elivery Day Year
Part II. Other significant conditions con	tributing to death but not resulting in the un	derlying cause given in Part I.			o the cause of death? Probably 4 1 Unknown
PAGETIS DISE	452-		24a. Was an autopsy performed?	prior to death?	utopsy findings available completion of cause of s
25. Was case referred to medical		26. Place of Death (Chec	ck only one)		
1 L Yes 2 A No	ospital: 1	3 DOA Other: 4 Nursing H	Iome 5 Residence	6 A Other (Spec	city) HOSPICE
27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year) 28b. Time of injury	28c. Injury at work? M 1 ☐ Yes 2 ☐ No	28d. Describe how inj	ury occurred	
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, stree building, etc. (Specify)	et, factory, office	28f. Location (Street a City or Town, Sta		ıral Route Number,
(Check 2 Medical Examine	cian: To the best of my knowledge, death oc er: On the basis of examination and/or investig Practioner: To the best of my knowledge, de	gation, in my opinion, death occurred	at the time, date and pla-	ce, and due to the	cause(s) and manner stated
29b. Signature and title of certifier		29c. License number	29d. D	ate signed (Mont	h, Day, Year)

JANUARY 19, 2010

CHAPLESST, SUITE 4105 BALTIMORE, MD 21204

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DOBERMAN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Michael Mac Ford 2010 10:00 P. M January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Carroll 2500 Bachman Valley Road Manchester . Social Security Number 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** (Month, Day, March 1 1XXM 2 □ F 218-38-4289 68 Yrs. Director 1941 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2XX No Maryland Carroll Manchester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States Funeral 2500 Bachman Valley Road 21102 America ral", or items? 12. Was Decedent Ever in U.S. Armed Forces? 12. Aryes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examir 1 Yes 2 No Specify 3 Widowed 4 Divorced Specify: Completed White Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Stock Broker 4 Financial Services Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Joseph S. Ford Lillian Gatch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Scott D. Ford (Son) 3404 Schaefer Drive, Hampstead, Maryland 21074 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date □ Burial 2XXCremation 3 □ Removal from State Jan.18 2010 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Catonsville, Maryland Signature of Funeral Service Licenses 22. Name and Address of Facility Eckhardt Funeral Chapel, P.A. <u>3296 Charmil Drive, Manchester, Maryland 21102</u> t 1. Fiter the disease, or complicate is that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between or heart failure. List only one cause on each line Imm diate Cause (Final disase or condition PANCROATIC Onset and Death Physician/ disase or condition resulting in death) YOWTHS Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence or): Exami anding physician and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ☐ Live Birth 2 ☐ Fetal dea☐ Pregnant at time of death in the past 12 months?
1 ☐ Yes 2 ☐ No cate has been signed by the atte page 2 should be detached for Month Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 X No 3 Probably 4 Unknown Completed 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform this certificate 1 Yes 2 🗌 No Yes completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be 1 ☐ Yes 2 X No 4
Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) s after death. 28b. Time of 28c. Injury at 28d. Describe how injury occurred Hospital or Attending Natural 2 Accider 5 Pending work?
1 \(\subseteq \text{Yes} \) 2 🗌 No Accident
Suicide Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours Medical Zertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, only one Certifying Nursa Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature

P.O. Division of Vital Records,

Box 68760

Baltimore, Maryland 21215-0036

State Registrar 30. Name and address of person who

31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

Dede Rd, Ste4, Finksbirg, MD 21048

pleted cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 00925 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month **Physician** 2010 05: 22 AM Jan Dorothy Mae Foreman /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Carrol1 Carroll Hospice Dove House Westminster 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 1 □ M 2 🗓 F 91 Director 212-03-9885 1918 Maryland May 7. Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 27 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 No Sykesville MD Carrol1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21784 USA permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hyglene. Important: If item 27 Is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Evantment and once. 1200 Old West Liberty Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: ğ Specify: 3 √Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Domestic Homemaker 10th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Florence Orem Milton Fetsch ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6634 monroe Ave. Sykesville, MD 21784 Austin Foreman Jr. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 1-22-10 Ellicott City, MD Good Shepherd Cem. gnature of Funeral Service Licensee 22. Name and Address of Facility Raight Funeral Rome & Chapel PO Box 195, 6416 Sykesville Rd, Sykesville MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final dementa Azheimers Sevila **Physician** 24eans disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, bading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal deal 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 No 2 1 No 1 □ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 🗌 No 2 🔲 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D31660 1912010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Avenue WESMINSTER MANYIOU 6 THOMAS K- CALVW 31. Date filed (Month, Day State Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

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Physicia	an.	1. Decedent's Name (First, Middle				-		2. Date of Dea		Year	3. Time of	
/Medic		GEORGE W. FAI		4				Januar		2010	10:25	a.M
Examin	er	4a. Facility Name (If not institution, Emerald Estates	give street and nui	mber)		Balti	r Location of Death IND T E	1	4c. Co	unty of Death		
Funeral		5. Social Security Number	6. Sex 1 🕅 M 2 🗆 F	7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	n <u>/ Ye</u> ar)	9. Birthp	lace (State o	r Foreign
Director		214-16-9172 Usual Residence of Decedent	123 W 2		91 Yrs.			(Month, Da) 4-11-1	118		<i>I</i> /C	
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Ra-f s	ecto		ltimre		Randa	allstown					1 🗆 Yes	2 No
with ti	Dir.	10e. Street and Number 8810 Harkate Way				10f. Zip Code 21133	}		10g. Citizer	of What Coun USA	try?	
death	Funeral Director	11. Marital Status	12. Was Dece	edent Ever in U.	S. 13.	Was Decedent of H	dispanic Origin? (S an, Mexican, Puert	pecify Yes or No-	14.	Race - Americ		
after or ite		1 Never Married 2 Marrie	If Yes, Giv	ve		1 ⊡Yes 2∭∑No	Specify:	o nican, etc.)	Sp	Black, White, e ecity: Afri		rican
hours	ted by	3 X Widowed 4 ☐ Divorced 15. Decedent*	Year or Da	ates:	16a. Dece	dent's Usual Occup	oation			of Business/Inc		
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and 2 fealth m 27 i		Mary Ann Byrd/ D	aughter	1001 6			ky, Randall			01	01-1-	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Dipartment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Evanting must be notified at 90.60.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 🔲 Removal from	State	emetery, crer	osition (Name of matory or other place Baptist Chu		Date	Semora	ion - City or To	wn, State	
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2018		Mando	1 M.	Myli	ν 9	200 Liberty	Road, Rand	dallstown,	MD 211	.33		
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bV		30. Name and address of person v	vho completed caus	e of death (Item	1 23a) (Type,	Print)	Rent Dole	#200 1	110111	colhil	15Mn	רווון
Sta	te	31. Date file (Month, Day, Year)	32. R	egistrar's Signa	ture.	2		· 2 w (JUJ	So Will	JIN,	out (
Registra	ar	JAN 2 0 201) Sevent	A.	park							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 10:16 A 2010 1 am 13 lanuary /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner The Johns Hopkins Hospital **Baltimore City** | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 10-10-1930 Birthplace (State or Foreign Country) 5. Social Security Number Age (In yrs. last birthday) **Funeral X** M 2 □ F Yrs 79 S.C. 250-46-5450 **Director** Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ▼ Yes 2 □ No MD Baltimore na 10e. Street and Number 10g. Citizen of What Country? 10f. Zip-Code 2213 E. 21213 USA Preston Street Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married Married 1 ☐ Yes 2**∑**If Yes, Give
Year or Dates 2**X** No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Black ģ Specity. 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) A K Roberts 5th grade Welder 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Henry Foster Rosetta Goins ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2213 E. Preston Street <u> Margaret Ruth Foster-Wife</u> Balto, MD 21213 20a. Method of Disposition 11 Burial 2 Cremation 3 Removal from State Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State permit. Page Department o Important: If any injury or once. 1-20-2010 Randallstown, Donation 5 Other (Specify) King Memorial Рk 22. Name and Address of Facility 21. Signature of Funeral Service Licensee March East F/H 1101 E.North Avenue Balto, MD 21202 23a. Part Three the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** Caraiac /Medical Due to (or as a consequence of) **Examiner** o bstruct nonic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed (or as a consequence of) and resulting in death) Last Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical the IF FEMALE: Live birth 2 Fetal death 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Pregnant at time of death 2 No by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tyes 2 🗌 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 🗌 Yes 2 No 2 No 1 Tes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 | Inpatient Other: 2 ER/Outpatient 3 □ DOA 4
Nursing Home 5 Residence 6 Other (Specify) Certification: To Director: After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident (Month, Day Year) Injury 1 ☐ Yes 2 ☐ No death. 3 Suicide 6 Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, by 4 - Homicide determined within 24 hours after To the Funeral Direct City or Town, State) 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

— Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MO RES-000 anuary 13, 2010

State Registrar

DHMH 17 Rev 1/2001

Tregioner Gate

30. Name and address of per-

31. Date filed (Month

HFFAM

2010

600 North Wolfe St, Baltimore, MD, 21287

n who completed cause of death (Item 23a) (Type, Print)

32. Registrar's

FOIL P

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death											00928			
			Registrar 1. Decedent's Name (First, Middle,	Cer	tificate of l	Death		2. Date of Dea	Reg. No.	2010				
	Physicia Medic		Alma Marie Fi	,						Januar	Day	2010 Year	3. Time of Death 3:25 AM M	
	Examir	er	4a. Facility Name (if not institution,	•	ber)		4b. City, Town, o				4c. 0	County of Deat	1	
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Maryland 21215-0036	be file lental rked c	2	Andrew Barthol	,	lik					(First, Middle, .		irname)		
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Σ.	and 2 seeth		Maureen Skayha	n/daughter	r	3900	Greenwa	y Bal	timoı	ce, MD	2121	L8 		
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 4 ☑ Donation 5 ☐ Other (Sp	3 ☐ Removal from S			sition (Name of atory or other plac	ce)	D	ate	20c. Loc	ation - City or	Town, State	
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			23a. Part 1. Enter the disease, or conshort, or heart failure. List on	. Do not ente	the mode of dyin	g, such as c	cardiac or	respiratory arm	est,		Approximate Interval Between			
~	Physician/ Medical	5 3	Immediate Osuse (Final disease or condition resulting in death)		ment								Onset and Death	
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		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (U	r as a conseque	snoe oij.								
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89 x	ending ending r use a	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	ome of pregnan irth 2 🗆 Fetal		Ectopic pregnance	2/			23	3d. Date of deliv	very	
Вох	ician: The law requires that the death certificate be executed certificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial-transit	Physician/M	in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	4 Pregna 9 Unkno	ant at time of de		Other (specify)	· y				Month	Day Year	
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Ä	The Is	Con								perfor	med?	death?		
Vital	sician: certifi rector,	Be	25. Was case referred to medical examiner?	Hospital:			Otho	ace of Death					A	
<u></u>	g Phys er this eral di	e: 10	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date of	injury 2	R/Outpatient 28b. Time of	3 DOA 28c. Injury	4 ∐ Nur		e 5 Reside		Other (Specif	ASCITED LVING	
0	anding rath. rr. Afte	icat	1 Natural 5 ☐ Pending 2 ☐ Accident ☐ Investiga		, Day, Year)	injury	work	? Yes 2 □ 1	- 1	o. Describe ne	ow injury o	Courted	/	
Division of	or Atter de firer de lirecto	Certificate:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	28e. Place of	f Injury - At hom , etc. (Specify)	ne, farm, stree	et, factory, office		28	3f. Location (St City or Town		lumber or Rura	l Route Number,	
ַ ב	pital o		29a. Certifier 1 Certifying P	hysician: To the bes	at of my knowles	dan danth or	anned at the time	-1-11-1	14	·				
:	to the Nospital or Attending Physician: within 24 hours after death. To the Funeral Director After this certific completed filled in by the funeral director,	Medical	(Check 2 ☐ Medical Exa	aminer: On the basis lurse Practioner: To	of examination a	and/or investig	ation, in my opinio	n death acc	urred at th	ne time date an	d nlaca ar	ad due to the ca	use(s) and manner stated	
_	70 th	-	29b. Signature and title of certifier	40			29c, License					signed (Month,		
			- gran	/w)			1/50	503		U	hnva	ry 6	410	
			30. Name and address of person wh	HOLLES V		23a) (Type, Pri 2 10 (1. Chival	4) (r	- ON	، ١٥٥٠	w	,		
	Stat	е	31. Date filed (Month, Day, Year)	32. Aeg	jistrar's Signatui		- A A	- 3/	100	V	- 17			
	Registra		JAN 20	2010	our to	7. 196								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician Month Year 11:48 PM Raymond Fogler 2010 18 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Upper Chesapeake M.C Harford BelAir . Age (In yrs. last birthday) 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months 1 X M 2 □ F Days Hours 219-40-6461 10-26-1943 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits Director Kingsville 1 ☐ Yes 2 X No Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8020 Yellowstone Road Be Completed by Funeral 21087 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 ∐Yes 2 Mar If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2 No Specify Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Balto. City Fire Dep. Diesel Engineer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Raymond Fogler ပ Mary Longo 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8020 Yellowstone Road Kingsville, Md. 21087 Mrs. Bonnie Fogler - Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State West Arundel Crem. 1-21-2010 Odenton, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Joseph N. Zannino Jr. F.H. 21. Signature of Funeral_Service Licensee Conkling St. Balto. Maryland21224 23a. Part1. Enter the use ise, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or he rt fail ve. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Find disease or con lition resulting in death) povalemic brs as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Esophagaa

Due to (of as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 😭 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe 1 □Yes 2 🗆 No 2 **X**No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred

Hospital or Attending Physician: 24 hours after death.
Funeral Director: After this certifica To the Hospital of within 24 hours at To the Funeral D

Funeral

Director

"natural", or items 23a or 28a-f show adical Evalutinet rust be notified at

1 and 2 should be Health and Mental

Pages 1 5

S tem 27

Physician

/Medical

Examiner

attending physician for use as the buria

has

Certification: To 28a. Date of Injury (Month, Day, Year) 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier (Check only one)

29c. License number

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

30. Name and address

Registrar

500 Upper

of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Maryla		epartment of F Certificate of L			ene g. No. 2010	00930
	Physici /Medio		1. Decedent's Name (First, Middle, Las	FINNE	7			2. Date of Death Month	Day Year 122010	3. Time of Death 4 P M
and a	Examin		4a. Facility Name (If not institution, give	e street and number)	nuc_	4b. City, Town, or	Location of Death	ML	4c. County of Death	
	Funeral Director		5. Social Security Number 6. S 213–18–7176	□M2DXF	s. last birthe	Months Days	If Under 24 Hrs/ Hours Min.	8. Date of Birth (Month, Day, 10–14–1	Year) 9. Birth	place (State or Foreign intry) RYLAND
70	yiarid how		Usual Residence of Decedent 10a. State 10b. County	10c. 0	City, Town o	r Location				10d. Inside City Limits
,	28a-fs	Director	MD N/A	E	ALTIM	ORE 10f. Zip Code		Lia	()411 1 0	1 X Yes 2 No
4	23a or	al Dir	2914 LOUDON AVE.			2121	6	10	g. Citizen of What Cou USA	nu y r
70	tems tems	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S.	13. Was Decedent of H If Yes, specify Cuba		ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White,	
:1215-0036	be new winn / z nous aret bean win the ivial year to the Wellygene Hygiene Hygiene do other than "natural", or items 23a or 28a-f show event, the Andical Exercite must be notified at	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 □ Yes 2 ☑ No If Yes, Give Year or Dates:		1 □Yes 2 No	Specify:		Specify: BLA	CK
21215-0036	"natu	Completed	15. Decedent's Ed (Specify only highest gra	ucation de co <i>mpleted)</i>	16a. D	ecedent's Usual Occup Give kind of work done of fe. DO NOT use retired	ation during most of workin	ng 1	6b. Kind of Business/Ir	ndustry
212	matic event, the Marin	Somp.	Elementary/Secondary (0-12)	College (1-4or 5+)		WELDER			ELECTRI	CAL
고 🕯	od othe	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name	(First, Middle, M	aiden Surname)	
Iryka Iryka	marke	P L	LEWIS C. HOLLAN 19a. Informant's Name/Relationship (7)		19b. N	failing Address (Street		TILGHMAN		in Code)
, Me	of Health a item 27 Is other trau		FRANCES BEVERLE	**		716 MOSHER			-	
Baltimore, Maryland	perimit. Tages 1 and 2 should be Department of Health and Menta Important; If item 27 is marked any injury or other traumatic evonce.		20a. Method of Disposition 1 ☐ Burial 2 ☐ cremation 3 ☐	Removal from State	Place of D cemetery,	isposition (Name of crematory or other plac	e) D	ate 2	0c. Location - City or T	own, State
altin	artmer sortant sortant injury		4 □ Donation S □ Other (Specify 21. Signature of Jouneral Service Liven	, UISO		REMATIONS	1-15-2	2010 B.	ALTIMORE, I	MARYLAND D A
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			23a. Part . Inter the disease, or comp shoc for heart failure. List only of Immedi & Cause (Final	plications that caused the de one cause on each line	ath. Do no	t enter the mode of dyin	g, such as cardiac o	r respiratory arre	st,	Approximate Interval Between Onset and Death
3	hysician /Medical		disease or condition resulting in death)	a. Due to (or as a conse	equence of	zocardia	e stry	archio	n	
E	xaminer	<u>.</u>	Sequentially list conditions,	b. Due to (or as a sons	and the last	JS				
) attack	id ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Sae to (3) de a conse	quei les on					
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Box	attending for use a	ian/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of preg	tal death	3 Ectopic pregnancy	y		23d. Date of deliv	very Day Year
O.G.	signed by the a	Physician/M	1 ☐ Yes 2 No 9 ☐ Unknown	4 ☐ Pregnant at time o 9 ☐ Unknown	f death	5 ☐ Other (specify)				Suj Toul
S , F	igned be deta	by P	Part II. Other significant conditions or	ontributing to death but not re	esulting in th	ne underlying cause give	en in Part I.		acco use contribute to	522
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Be	ate has	Completed						24a. Was an autopsy perform 1 ∐Yes 2	prior to co	opsy findings available ompletion of cause of
/ita	certificate h	Be C	25. Was case referred to medical examiner?	Lt- mital:		- lou	26. Place of Death		<u> </u>	
of Phys	er this	n: To	1 Yes 2 No 27. Manner of Death	Hospital: 1 ☐ Inpatient 2 [28a. Date of Injury	28b. Tin	ne of 28c. Injury	y at 2	ne 5 Resider 28d. Describe how	nce 6 Other (Spec	ify)
sion	ter death. rector: After this by the funeral o	catio	Natural 5 Pending investigation		Inju	M 1 🗆	Yes 2 □ No			
Division of Vital Records,	s after death.	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm cify)	, street, factory, office	2	28f. Location (Stre City or Town,	eet and Number or Rui State)	al Route Number,
Division of Vital Records, P.O. Box to the Hospital or Attending Physician: The law requires that the death cer	within 24 hours after To the Funeral Discompletely filled in	Medical (29a. Certifier (Check only one) Certifying Ph 2 Medical Exam	ysician: To the best of my kininer: On the basis of examinand manner stated.	nowledge, on ation and/	death occurred at the time or investigation, in my o	ne, date and place, a pinion, death occurr	and due to the ca ed at the time, da	use(s) and manner as te and place, and due	stated. to the cause(s)
Poft to th	within To th	Me	29b. Signature and title of certifier	W. Sterry	ant	29c. License	079C	29	d. Date signed (Month	10ay, Year) 2010
	H		30. Name and address of person who	completed cause of death (Ite	em 23a) (Ty	pe, Print)	1 (N) 4	-0 th 57	1, Balto	M2 21211
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Sign	nature	11	1 201			THE WAY
	Registr	ar	JAN 2 0 2010	Geneval B.	park					

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	Physicia		Decedent's Name (First, Middle, La Thomas	st) Ha	rt	Fi	sher				2. Date of De Month Januar	Da	y Year 7 2010		3. Time of Death 12:50 A ^M
	Medic Examin		4a. Facility Name (if not institution, give		ber)		4b. City, To						. County of De	ath	
1	Funeral		Suburban Hospi 5. Social Security Number 6.8		7. Age (In yrs. i	last birthdav)	If Under 1		resda If Under		8. Date of Bir	th.	Montg		ce (State or Foreign
	Director			X M 2 □ F	92	Yrs.		Days	Hours		Dec. 9	y, Year) 191	l 7 Ke	ountry	
	nd how at	'n	Usual Residence of Decedent 10a. State 10b. County		10c. Cit	ty, Town or Loc	ation							100	d. Inside City Limits
	Maryla :8a-f s	Director	MD Mongome	ery			В	ethe	esda						1 ☐ Yes 2 🔀 No
	th the h 3a or 2 t be no	al Di	10e. Street and Number 5321 Carve1 Rd.				10f. Zip C					~	tizen of What C		
	eath wi ems 2 r mus	Funeral	11. Marital Status	12. Was Deced			Vas Deceder	2081	panic Orig	gin? (Spe	cify Yes or No-	_	nited S		
36	ifter de ", or it	ρ	1 Never Married 2 X Married	Armed Ford 1 X Yes If Yes, Give	ces? 2 No		Yes, specify				Rican, etc.)		Black, Wh Specify:	ite, etc	3.
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2	d withi lygiene ther th nt, the	do I		4		Sale	s Adm						siness	For	m Co.
Maryland	be file lental H rked or tic ever	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surna P Albert Teasdale Fisher Eleanor Hart Anderso								*					
Aar V	should and N is ma rauma	ľ	19a. Informant's Name/Relationship (ė.						l Route Numbe				
<u>ح</u> نه	and 2 Health tem 27		Martha Carr Fish 20a. Method of Disposition	ner / wi		D 3 Z I	Carv		κα.,		Betheso Date		1D 20 ocation - City of	816	
) E	Page 1 nent of ant: If i		1 ☐ Burial 2 【 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Control of the Cont	Removal from S	State	cemetery, crem esapeak	atory or oth	er place,			_		tsvill		
→ <u>T</u> Baltimore.	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Department of Health and Mental Hygiene Important: If from 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licen	39	M003	82 Ra	Name and RP Fu	Address nera t Av	of Facility	d Cr Silv	ematior er Spri				20910
7			23a. Part 1. Enter the disease, or comshock, or heart failure. List only of	aplications that ca	aused the deat	th. Do not ente	r the mode	of dvina.	such as	cardiac o	r respiratory an	rest.		A	Approximate nterval Between
2	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)	, (L	MGA	CVA									Onset and Death
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173	ertifica ding ph	/Me	IF FEMALE:	23c. If yes, outc	ome of pregna	ancv						1			
XOX	law requires that the death certifics has been signed by the attending pe 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No	1 🔲 Live B 4 🔲 Pregn	Birth 2 Teta ant at time of	aldeath 3 🗆	Ectopic pre Other (spec	egnancy c <i>ify</i>)	•				23d. Date of d Month	-	ay Year
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ISHER on of Vita	Physical this care direction	e: 10	1 ☐ Yes 2 😾 No 27. Manner of Death	1 Xii 28a. Date o	f injury	ER/Outpatien 28b. Time of		Other	4 ∟ Nu		me 5 Resid			ecify)	
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Division	or Att after d Direct in by t	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place c	of Injury - At ho g, etc. <i>(Specif</i>)	ome, farm, stre	et, factory, o	office		2	28f. Location (S City or Tow			ural Ro	oute Number,
HART	Hospit 4 hour Funerated fills	Medical		iner: On the basis	of examinatio	n and/or investi	gation, in my	y opinion	, death oo	curred at	the time, date a	ind place,	and due to the	cause	e(s) and manner stated.
F	To the I within 2 To the I	Σ	only one) 3 ☐ Certifying Nur 29b. Signature and title of certifier	- /actioner: 10	Cure Dest or m	y Niowiedge, d	29c. L	License r	number	and place			e signed (Mon		
1	5+1		Mn	J	JWA			1)6 5	312			1/7	10		
			30. Name and oddress of person who Sudarshan Siva, M			, , , , .	,	Rd.,	Betl	hesda	a, MD	208	314		
	Stat Registra		31. Date filed (Month, Day, Year) JAN 20 201	82. Re	gistrar's Sign	ture for	W								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible 2010 0932 State of Maryland / Department of Health and Mental Hygiene

			1- For State Certifi Registrar	cate of Death	Reg. No.	
Physi			Decedent's Name (First, Middle,Last)		2. Date of Death	3. Time of Death
	cal Exami	iner	Edward Lee	Gardner	January 11, 2010	1424 nrs
			Facility Name (if not institution, give street and number) Woodland Avenue	4b. City, Town, or Location of Death Baltimore		of Death
	Eumanal		Social Security Number 6. Sex 7. Age (In yrs. last be a security Number 6. Age (In yrs. last be a security Number 6. Age (In yrs.		N/A 8. Date of Birth (MM/DD/YYYY	0 0 0:45-1 (01-1
	Funeral Director			Months Days Hours Min.		Foreign
			214-68-2497 124M 2 F 55	Yrs.	05/29/1954	Country) MD
	he Maryland or 28a-f show any ifred at once.	Director	10a. State 10b. County 10c. City, Tow	n or Location		10d. Inside City Limits
			MD N/A	Baltimore		1 X Yes 2 No
			MD N/A 10e. Street and Number	10f. Zip Code	10g. Citizen of Wh	
			2602 Nandland Amenus	21215		•
	with t is 23g		2603 Woodland Avenue 11. Marital Status 12. Was Decedent Ever in U.S.	21215 13. Was Decedent of Hispanic Origin? (Sp	U.S.A pecify Yes or No-	American Indian, Black,
	Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Funeral	1 Never Married 2 Married Armed Forces? 1 Yes 2 X No	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.) White	e, etc.
			3 Widowed 4 Divorced If Yes, Give Year or Dates:	1 Yes 2 No specify:	Specify:	Black
			15. Decedent's Education (Specify only highest grade completed) 16a	. Decedent's Usual Occupation (Give kind of viduring most of working life, DO NOT use reti		siness/Industry
			Elementary/Secondary (0-12) College (1-4 or 5+)	dailing most of working me. Do Not assistant	Balti	more Home
			10th Grade 17. Father's Name (First, Middle, Last)	House Insulation		sulation
	filed I Hyged other				(First, Middle, Maiden Surname)
	212 ald be Menta mark	o Be	Herman Cannie Gardner 19a. Informant's Name/Relationship (Type, Print)	Sr. Annie 9b. Mailing Address (Street and Number or F	Pearl	n State Zin Code)
	MD 21 nd 2 should I alth and Mer m 27 is man	-				
	and and Health		20a. Method of Disposition 20b. Place	2603 Woodland Ave.	Date 20c. Location -	City or Town, State
	Baltimore, permit. Pages 1 at Department of Her important: If ite njury or other tr		1 Burial 2 Cremation 3 Removal from State Joseph	etory or other place)	14.5.14.0	
	iltin nit. Pa artmer ortan ry or	- 5	4 Donation 5 Other Specify: And 21. Signature of Funeral Service Licensee	Crematory 01/	16/10 Baltim	ore,MD
	Balt permit. Departi Importi injury		Dietrich N. William	Joseph H. Brown	Jr. Funeral	Home
	Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval			
	/Medical Examiner		failure. List only one cause on each line. Immediate Cause (Final disease a Hypertensive atherosclerotic cardiovascular disease Death			
	Exammer		or condition resulting in death) Due to (or as a consequence of):	erosererotre cardiova	Scular ulsease	
	Sequentially list conditions, b					
		je	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated c			
	# 5 is	Examiner	events resulting in death) Last Due to (or as a consequence of):			
	and trans		d			
	ficate be executed g physician and s the burial - transit	/Medical	☐ AMENDED 23a,27,	permE, g899 1/28/10 T	T	
			IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth	,	23d. Date of	7. 7.
	Sox 68 leath certifi e attending for use as i	cial	past 12 months? 4 Pregnant at time of death	 Fetal death 3 Ectopic pregnal Other (Specify) 	ncy Month	Day Year
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Physician	1 Yes 2 No 9 Unknown 9 Unknown	o li otter (opeany)		
			Part II. Other significant conditions contributing to death but not resulting	ng in the underlying cause given in Part I.	23e. Did tobacco use contri	
		Completed by			1 Yes 2 ✔ No 3	1 Yes 2 No 3 Probably 4 Unknown
						Vere autopsy findings available rior to completion of cause of
		틹			performed? d	eath? Yes 2 No
		BB C	25. Was case referred to medical	26.Place of Death (Check of		703 2 100
			examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/C	Outpatient 3 DOA Other Nursing	Home 5 Residence 6 ₩	Other: Scene
				Time of Injury 28c. Injury at Work?	28d. Describe how injury occurre	ed
			1 X Natural 5 Pending 2 Accident Investigation (Month, Day, Year)	1 Yes 2 No		
		Ę	3 Suicide 6 Could not be 28e. Place of Injury - At home,	arm, street, factory, office building, etc.	 Location (Street and Number or Town, State) 	er or Rural Route Number, City
		edical	4 Homicide determined (Specify)		or rown, orace)	
-			29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)			
			and manner stated. 29b. Signature and the of certifier.			
			6) A GO A GO A GO A GO A GO A GO A GO A G	29c. License number		d (Month, Day, Year)
	l	ļ	Ulle Waller Well	O.C.M.E.	January 12	, 2010
			 Name and address of person who completed cause of death (Item 23a) Victor Weedn MD JD Assistant Medical Examiner 	111 Penn Street, Baltimore, MD 2	21201	
	St	ate	31. Date filed (Mor) ANY 2010 32 sections Signary			
	Regist		and the same of th			
			OCME			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State of Maryland / Dep	eartment of Health and Nertificate of Death		giene leg. No 2010	00933
)	Physicia		1. Decedent's Name (First, Middle, Last) Philip Lawrence	George	2. Date of Deal Month		3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give street and number) FYANKLIN SQUARE HOSPITAL	4b. City, Town, or Location of Death		4c. County of Death	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday 220–03–4296 1 N 2 F 93 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day Jan. 31	(Year) Cou	place (State or Foreign Intry) 1and
Aaryjand	fshow	jo.	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L				10d. Inside City Limits 1 ☐ Yes 2 ☑ No
with the A	al", or items 23a or 28a-f shov	Director	MD Baltimore 10e. Street and Number	10f. Zip Code		Og. Citizen of What Cou	-
er death	tems 23	Funeral	5804 Gambrill Road 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto		United Stat 14. Race - Ameri Black, White,	ican Indian,
0036	"natural", or items	[호	1 ☐ Never Married 2 ☐ Married If Yes, Give 1 ☐ New Year or Dates: WWII	1 ∐Yes 2∭∑ No <i>Specify:</i>		Specify: Wh	nite
SCOVOR PRINCE altimore, Maryland 21215-0036	ntal Hygiene. d other than "natu event, II a Medical	Completed	(Specify only highest grade completed) (Giv. Elementary/Secondary (0-12) College (1-4or 5+)	edent's Usual Occupation be kind of work done during most of work DO NOT use retired)	ing	16b. Kind of Business/Ir	dustry
E 9	e d d	Be	17. Father's Name (First, Middle, Last)	Driver 18. Mother's Name		ŕ	
aryla should	Department of Health and Men Important: If item 27 is marke any Injury or other traumatic once.	10		ing Address (Street and Number or Rura		r, City or Town, State, Zi	
re, M	Health tem 27 i		20a. Method of Disposition 20b. Place of Disp	Gambrill Road Wi		sh, Marylan	
GC DV OR altimore, N	tment of tant: If i		4 Donation 5 Other (Specify) Oak Lawr	n Cemetery 1/21/20	010	Baltimore,	Maryland
Balti permit.	Depar Impor any Ir		21. Signal ure of Funeral Service ticensee	2. Name and Address of Facility Duda-Ruck Funeral 1 1922 Wise Ave. Dur	Home of	Dundalk, In arvland 21	nc. 222
Ph	nysician		23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	ter the mode of dying, such as cardiac (or respiratory arm	est,	Approximate Interval Between Onset and Death
//	Medical caminer		Due to (or as a consequence of):	Olefdina 9			(a Days
onted	nd ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events				0001
8760, Cate be executed	physician and s the burial-transit	dical Exa	resulting in death) Last Due to (or as a consequence of): d.				
Box 6	attending for use as	Physiclan/Mec		☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of deliv Month	rery Day Year
rds, P.	n signed by		Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.		pacco use contribute to t	
Division of Vital Records,	within 24 hours after death. To the Funeral Director: After this certificate has been signed by the i completely filled in by the funeral director, page 2 should be detached in the funeral director, page 2 should be detached in the funeral director.	Completed by	11		24a. Was ar autops perform	y prior to co ned? death?	opsy findings available ompletion of cause of
· Vita	s certific director,	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatie	26. Place of Death	(Check only on		
Vision of	ith. :: After thi e funeral c	tion: T	27. Manner of Death 1			w injury occurred	<u>y)</u>
Divis	rs after dec al Director ed in by th	Certification: To	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, structure building, etc. (Specify)	reet, factory, office	28f. Location (St. City or Town	reet and Number or Run n, State)	al Route Number,
the Hospi	nin 24 hour the Funer	Medical	29a. Certifier (Check only one) 1 ★ Certifying Physician: To the best of my knowledge, deat 2 ★ Medical Examiner: On the basis of examination and/or in and manner stated.	h occurred at the time, date and place, ivestigation, in my opinion, death occurr	and due to the ca ed at the time, da	ause(s) and manner as a ate and place, and due t	stated. o the cause(s)
	With To 1	Σ	29b. Signature and title of certifier hay sangulam. 1 M.D.	29c. License number		9d. Date signed (<i>Month</i> ,	*
3	+1	Ī	30. Name and address of person who completed cause of death (Item 23a) (Type, DY . A Jay 6an 9mam 9000 Franklin Squa			21237	
	Stat Registra	·	31. Date filed (Month, Day, Year) — 33 Registrar's Signatus JAN 2 0 2010	relati			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 00934 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2010 James Watson Galway, Jr. January 6:49a /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carroll Carroll Hospital Center Westminster 8. Date of Birth (Month, Day, Oct 18 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 1925 Months Days Hours 84 MD 212-20-6515 Director Usual Residence of Decedent 10h County 10c. City, Town or Location 10d. Inside City Limits 10a. State show ms 23a or 28a-f shor must be notified at MD Howard Laurel 1 ☐ Yes 2X No Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? with 20723 9450 Decatur Road USA Funeral death v th and Mental Hygiene. 7 is marked other than "natural", or items : traumatic event, the Medical Examiner my 12. Was Decedent Ever in U.S. Armed Forces? 1 [X/es 2 □ No WWII If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify: white ₽ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) U.S. Military U.S. Army Captain 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mabel Estella Crook James Watson Galway Sr. ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or other trau Janet Fairbank (daughter) 1303 Greenway Ct., Westminster, MD 21157 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3-10-10 Arlington National Arlington, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Haight Funeral Home & Chapel Page Harght Herbert P.O. Box 195 Sykesville, MD 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine law requires that the death certificate be executed emenha attending physician and for use as the burial-trans Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? 1 □ Yes 2 □ No Month Day Year ned by the a 9 Unknown signed by t t be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ≥ icate has been sig ; page 2 should b 3 Probably 4 ☐ Unknown 1 Tyes 2 IDNO Completed 24a. Was an Were autopsy findings available prior to completion of cause of certificate has autopsy performed' death? 2 Ne 1 □Yes 2 1 No 1 ☐ Yes funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Unpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner eath 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After Attending 1 Latural 5 Pending Hospital or Attendi 24 hours after death. Funeral Director: A 1 ☐ Yes 2 ☐ No death. 2 Accident investigation filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only

29b. Signature and title of

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print).

DR. Kaman B. Kaneya, 349 Malcalm sluby Westminite MD 2(151) K 32. Registrar's Signature 31. Date filed (Month, Day Registrar

29d. Date signed (Month, Day, Year)

			1 - State Registrar			Certificate o	of Death		eg. No. 20	0 00935
	Physici	an	1. Decedent's Name (First, Middle, Last					2. Date of Death Month	1 Day 2010 Year	
and a	/Media Examir		JOHN EDWARD (4a. Facility Name (If not institution, give			4b City Town	n, or Location of Deat		4c. County of De	6:45 P M
	Lxaiiiii	ici	NATIONAL NAVAL			15. 519, 1511	BETHESDA		1	TGOMERY
	uneral irector		213 30 7240	x 7. Ag M 2□F	e (In yrs. last birth 68 Y	nday) If Under 1 Ye Months Da			^Y 1941 Ne	rthplace (State or Foreign Country) WYork
and	we		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits
Maryl	-f sho	ţō	Maryland Montgome	rv	, , , , , , , , , , , , , , , , , , , ,		rmantown			1 ☐ Yes 2 🔀 No
h the	or 28a	Director	10e. Street and Number		I	10f. Zip Cod		10	g. Citizen of What C	ountry?
ath wi	23a ust b	ral	22 Sunnyview Co	ourt			20876		United S	tates
d 21215-0036 filed within 72 hours after death with the Maryland Hygiene.	Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examination in the maillied at once.	d by Funeral	11. Marital Status 1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 ⊠Yes 2 ☐ N If Yes, Give Year or Dates:	No	13. Was Decedent of If Yes, specify C	of Hispanic Origin? (Suban, Mexican, Puerl No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Am Black, Whi Specify: Wh	te, etc.
5-0	"natu	etec	15. Decedent's Edu (Specify only highest grad	cation e co <i>mpleted</i>)	16a. [Decedent's Usual Oc Give kind of work do	cupation ne during most of wor	kina 1	6b. Kind of Business	
within ene.	than De Mg	Completed	Elementary/Secondary (0-12)	College (1-4or 5	i+)	life. DO NOT use rel Officer	ne during most of wor ired)	0	nited Sta Armv	tes
filed 2	other rent, I	Be Co	17. Father's Name (First, Middle, Last)			OTTICCI	18. Mother's Nan	ne (First, Middle, M		
/lar uld be Menta	arked atic ev	To B	Edward John Gi	abowski			Gertru	de LaCost	e	
altimore, Maryland 21215-0036 rmit. Pages 1 and 2 should be filed within 72 hours aft partment of Health and Mental Hygiene.	n 27 is ma er trauma		19a. Informant's Name/Relationship (Ty Jennifer Norris/Wi	, ,	19b. N	Mailing Address (Stre 2 Sunnyvie	eet and Number or Ruew Court, Ge	ural Route Number, ermantown	City or Town, State, , Marylan	Zip Code) d 20876
more Pages 1	nt: If iten iry or oth		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	20b. Place of E cemetery, Montgon Cremato	Disposition (Name of crematory or other position, Inc.)		ary 20,	oc. Location - City of	
Balti permit. Departn	Importa any Inju once.		21. Signature of Funeral Service License	// 17	101498					uneral home/ Avenue
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	edical miner		resulting in death)	-	a consequence of)			202102		
LAU		<u>-</u>	Sequentially list conditions,	Duri de Christi	n belegge Chine (C. 196					
uted	dansit	Examiner	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (3) as a	a consequence of)					
C, exec	an an ri al -tra	ш	resulting in death) Last	Due to (or as a	a consequence of)	•				
68760, ificate be e	ng physician and as the burial-transit	Medical								
. BOX 68 / 60, death certificate be executed		/Mec	IF FEMALE:	Do Muse subserve						
BOX death ce	attendir for use	Physician/	in the past 12 months?	3c. If yes, outcome of 1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal death	3 ☐ Ectopic pregna 5 ☐ Other (specify)			23d. Date of de Month	livery Day Year
	by the ached	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown	anno or death	эш отнет (<i>specity)</i>				
ords, P.O	signed by the aid be detached f	by P	Part II. Other significant conditions con	tributing to death bu	it not resulting in th	ne underlying cause	given in Part I.	23e. Did toba	icco use contribute to	the cause of death?
ecords,	s peen s							1 ☐ Yes	2 □ No 3 □ P	robably 4 🔀 Unknown
() > ·	nasb e 2 sk	Completed						24a. Was an autopsy	24b. Were a	utopsy findings available completion of cause of
 The	Arrer mis certificate nas funeral director, page 2							performe 1 □ Yes 2	ed? death?	s 2 No
VII(all siclan: T	recto	∞	25. Was case referred to medical examiner?	ospital:			thor	th (Check only one)		
2 ਵ	er tnis eral di	2	1 ☐ Yes 2 ☑ No	1 Inpatie	nt 2 ER/Outpa	ALIENT 3 DOA	4 LI Nursing H	ome 5 Residen 28d. Describe how	ce 6 ☐ Other (Spe	ecify)
	e fune	atio	1 Natural 5 Pending 2 Accident investigation	(Month, Day	(Year) Inju	ry W	ork? ☐ ☐ Yes 2 ☐ No	26d. Describe flow	injury occurred	
VIS r Atte	by th	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Inju	ry - At home, farm	street, factory, office		28f. Location (Stre	et and Number or R	ural Route Number,
italo Lisaft	ed in							City or Town,		
To the Hospital or Attending Physician: within 24 hours after death.	pletely fi	Medical	29a. Certifier 1 → Certifying Phys (Check only one) 1 → Certifying Phys 2 → Medical Examir	ician: To the best o er: On the basis of and manner stat	examination and/o	leath occurred at the or investigation, in my	time, date and place opinion, death occur	, and due to the cau red at the time, dat	use(s) and manner a e and place, and due	s stated. e to the cause(s)
- 5 ± 5	COUT	Σ	29b. Signature and title of cartifier	>	10	29c. Lice	nse number	290	d. Date signed (Mont	h, Day, Year)
(1)	1			5 - 1	N(8)		0101245334	(VA)	In 15	2010
251	1	;	30. Name and address of person who con			pe, Print)			MEDICAL CE	NTER
	Stat	e :	GREGORY S. FUHRE 31. Date filed (Month, Day, Year)	32 Pegistra		P54	BETHESD	A MD 2088	39-5600	
В	egistra	~	JAN 20 201	0	1	1				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2010 Jane E. Gordon January 2:25 PMMedical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) New York 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, eb. 13. 1 □ M 2 🛣 F Days Hours **Director** 078-12-2215 87 Feb. Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland | Montgomery Darnestown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral hours after death with 14900 Kelley Farm_Drive 20874 United States 11. Marital Status 12 Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces Black, White, etc. ģ 1 Never Married 2 X Married Yes 2 X No Maryland 21215-0036 1 Yes 2 No Specify: Completed 3 Widowed 4 Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) should be filed within 72 h and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) P James Fitzsimmons Jane Kelly 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard J. Gordon/Husband 14900 Kelley Farm Drive, Darnestown, Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Arlington National Cemetery crematory or other place) February 8, 1 🔀 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2010 Arlington, Virginia Signature of Funeral Service Licenses Robert A. Pumphrey Funeral Home/Rockville, Inc. M01548 300 West Montgomery Avenue, Rockville, Maryland 20850 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph sician/ disease or condition resulting in death) Pneumonia month Medical Due to (or as a consequence of) **Examiner** Pleural Effusions 1 month Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examiner and -transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) burialinding physician use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death nse 23b. Was decedent pregnant 23d. Date of delivery for in the past 12 months? Year Pregnant at time of death Unknown Dav hed by the ai g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed Atrial Fibrillation, Respiratory Failure, 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? Renal Insufficiency, Neutropenia 24a Was an autopsy 1 Yes 2 No Yes 2 X No completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 🗓 No Other: မှ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred X Natural 5 Pending injury Accident 1 ☐ Yes 2 ☐ No. after death Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the I only one) 29b. Signatu 29c. License number D0069336 January 12, 101 and address of person who completed cause of death (Item 23a) (Type, Print)

10

DHMH 17 Rev 7/2009

State Registrar 32. Registrar's Signature

9901 Medical Center Drive, Rockville, MD 20850

<u>Janelle Naomi Williams, M.D.</u>

31. Date filed (Month, Day, Year)-

0-00512	Cai	Please Type or Print in Black Indelible Ink. Ensur				0000
arius Dwayne	Goil	otate of Maryana, Boparanont of Floatar a	nd Mental Hy	glene	2010	0093
-		1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last)			g. No.	[0.T., (D.)
Physic Medical Exam				 Date of Death Month January 18 	Day Year	3. Time of Death 2025 hrs
		Dallas Bwayiie Goliico	or Location of Death	January 10	4c. County of Death	
		University Hospital Baltimore			n/a	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Yes	ar If Under 24Hrs.	8. Date of Birth		hplace (State or
Director		212-31-9148 1 1 M 2 F 19 Yrs. Months Day	ys Hours Min.	10/19/	1990 Foreig	in untry) MD
		Usual Residence of Decedent		1.07.07		
' any		10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
Maryland 28a-f show d at once.	৯	MD n/a Baltimore				1 X Yes 2 No
Maryl 28a-1 d at c	Director	10e. Street and Number 10f. Zip Code		100	g. Citizen of What Cour	ntry?
with the Maryland ns 23a or 28a-f sho be notified at once.		616 Murphy Lane 2120)		USA	
th witi ems 2 t be n	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hi 1 X Never Married 2 Married Armed Forces? 13. Was Decedent of Hi 15. Yes, specify Cubar			14. Race - Ameri White, etc.	can Indian, Black,
er dea	Fur	1 Yes 2 X No				
rs afte ural", mine	by	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No		ork done	Specify:Blac	
2 hou "nat	ted	Elementary/Secondary (0-12) College (1-4 or 5+)			TOD. KING OF BUSINESS/F	idusi y
36 thin 7 than than	nple	9 Food Service	Employee		Popeye's	
5-0(ed wii lygier other	Completed		18.Mother's Name (First, Middle, Ma	aiden Surname)	
MD 21215-0036 d 2 should be filed within 72 hours after death with the Maryland thth and Mental Hygiene. n 27 is marked other than "natural", or items 23a or 28a-f she numatic event, the Medical Examiner must be notified at once	Be	2110110110	Michelle			
21 hould hould Me is ma	2	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street				Zip Code)
MD nd 2 sho alth and m 27 is		Catherine Lyles—Grandmother 616 Murphy La 20a. Method of Disposition (Name of ce				
of He If ite		1 VBurial 2 Cremation 3 Removal from State crematory or other place)	· 1		20c. Location - City or	
iment tant:		4 Donation 5 Other Specify: Mt. Zion Cemetery			Baltimore,	MD
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Montal Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner		21 Signature of Euneral Service Licensee 22. Name and Address John L. Wi 4517 Park	s of Facility Lliams Fu	meral,D	irectors	P1215
		23a.Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying,				Approximate Interval
Physician //Medical		failure. List only one cause on each line.	, such as cardiac or a	espiratory arres	it, shock, or heart	Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):				Deadi
		Sequentially list conditions, b				
	ner	if any, leading to immediate Due to (or as a consequence of):				
	Examiner	Culsease or injury that initiated events resulting in death). Last use to (or as a consequence of):		_		
executed an and ai - transit		d.				
	lical	UNPENDED AMENDED				
760, cate b	sician/Med	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery	
68 certific nding se as t	ian	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3	Ectopic pregnance	су	Month D	ay Year
30X death e atter	ysic	1 Yes 2 No 9 Unknown 9 Unknown			İ	
that the detached	Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause of	given in Part I.	23e. Did toba	acco use contribute to t	he cause of death?
cords, P.C. law requires that has been signed to see the see t	d by			1 Yes	2 No 3 Prob	ably 4 Unknown
rds requi	Completed			24a. Was an		opsy findings available
e law te has ge 2 s	Ę			autopsy	ed? death?	ompletion of cause of
tal Reco		25. Was case referred to medical 26. Place	e of Death (Check on	1 Yes 2	No 1 Yes	2 No
of Vital Records, ng Physician: The law require where this certificate has been simeral director, page 2 should b	o Be	augustinas?	Other Nursing		esidence 6 Other:	
Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be hin 24 hours after death. the Funeral Director: After this certificate has been signed by the attending physici piptetely filled in by the funeral director, page 2 should be detached for use as the burn	2	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury	ıry at Work? 2	8d. Describe ho	w injury occurred	
Division tal or Attendir rs after death. at Director: A	흹	1 Natural 5 Pending Jan 18, 2010 1435 hrs 1	Yes 2 V No	ubject shot		
ViSI or At fier d Direct in by	<u>≅</u>	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office b	ouilding, etc. 2		eet and Number or Run	al Route Number, City
Division To the Hospital or Attend within 24 hours after death To the Funeral Director:	Certification:	4 V Homicide determined (Specify) Local Street	60	or Town, Stat 00 Blk. W. Hof	fman Street, Baltimo	ore, MD
To the Hospital within 24 hours To the Funeral completely filled		29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, day			,	
To the Ho within 24 P To the Fur completely	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion and manner stated.				
	2	29b. Signature and title of certifier 29c. Licens			29d. Date signed (Mon	
		0.C.I	IVI. C.		January 19, 2010	
		 Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner 111 Penn Street, 	Baltimore MD	21201		
	ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	, Daidinole, MD	- 1201	·	

DHMH 17 Rev 1/2001 OCME 2006

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		,	For State Registrar	State of Mar			nt of Hea te of De			Reg. No	2010	00938
-4	Physici /Medic		1. Decedent's Name (First, Middle, La Kathy Suzanne Go:	,					2. Date of D Month Januar		y 2010 Year	3. Time of Death 1:30 P M
9	Examir		4a. Facility Name (If not institution, given 15 Widows Watch			Be	rlin	ocation of Death		4c.	. County of Death	
	Funeral Director		5. Social Security Number 213-84-1302 Usual Residence of Decedent	1□M 2ĂF	(In yrs. last birthd	Months		f Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D Jan. 2	ay, Ye <i>ar)</i>	Cou	place (State or Foreign intry) Maryland
	he Marylan 8a-f show otified at	Director	10a. State 10b. County Maryland Worcest		Berlin							10d. Inside City Limits 1 ☐Yes 2 ☐No
	th with the 23a or 2 ast be no		10e. Street and Number 15 Widows Watch	Court			ip Code 21811				izen of What Cou SA	intry?
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give Year or Dates:		3. Was Deco If Yes, sp 1 ☐ Yes		anic Origin? (Sp Mexican, Puerk Specify:	pecify Yes or N Rican, etc.)	0-	14. Race - Ameri Black, White Specify:	, etc.
Baltimore, Maryland 21215-0036	within 72 ho iene. than "natur the Medical I	Completed	15. Decedent's E (Specify only highest gr Elementary/Secondary (0-12)	ducation ade completed) College (1-4or 5+)	(G lif	cedent's Us ive kind of w e. DO NOT	use retired)	on ing most of work	king		ind of Business/Ir Restaura	ndustry
and 2	d be filed ental Hygi ced other c event, t	Be	17. Father's Name (First, Middle, Last Melvin George Lie	")			18	3. Mother's Nam	,	e, Maiden	Surname)	
Maryl	d 2 shoule th and Me 7 Is mark traumati	2	19a. Informant's Name/Relationship Meghan S. Gorrera	(Type. Print)		-	ss (Street and	d Number or Ru	ral Route Num	ber, City o	or Town, State, Zi and, 218	. ,
lore,	it of Healing of other		20a. Method of Disposition 1 Burial 2 Cremation 3	Removal from State	20b. Place of Di cemetery,	sposition (Na crematory or	ame of r other place)		Date	20c. Lo	ocation - City or T	own, State
Baltim	permit. Pa Departmer Important: any injury once.		4 □ Donation 5 ☒ Other (Special Signature of Funeral Service ☑ Se		Bel Air	22. Name a	and Address o	of Facility Mc	Comas .	Fune	el Air, ral Home yland 21	•
	Physician /Medical Examiner		23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. MALIGA				such as cardiac				Approximate Interval Between Onset and Death
,00	cate be executed physician and the burial-transit	Examiner	Sequentially list conditions and any leading to amount of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	C	consequence of):							
P.O. Box 68760,	eath certifi attending for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	d. 23c. If yes, outcome pf 1 □Live birth 2 4 □ Pregnant at tii 9 □ Unknown	Fetal death	3⊟Ectopic 5⊟ Other (s					23d. Date of deliv	very Day Year
	w requires that the d been signed by the should be detached	by	Part II. Other significant conditions	contributing to death but	not resulting in th	e underlying	cause given i	in Part I.		tobacco		the cause of death?
Division or Vital Records,	aw s b	Completed							24a. Wa auto peri 1∐ Yes	opsy ormed2_	, death?	topsy findings available completion of cause of
r Vita	ysician is certifi director	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient	2 ☐ ER/Outpa	tient 3 ☐ C	Other:	 6. Place of Dea 4 ☐ Nursing H 	3.6		6 ☐Other (Spec	ifv)
sion o	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page?	Certification: T	27. Manner of eath Matural 5 Pending			ry M	28c. Injury at Work? 1 ☐ Yes	<u>-</u>	28d. Describe	how inju	ry occurred	
Divi	pital or A: nurs after c eral Direc illed in by		4 Homicide determined determined building, etc. (Specify)							e)		
er.	he Hosi in 24 ho he Fune pletely f	Medical		miner: On the best of miner: On the basis of e and manner state	xamination and/o							
	To t With To t	Σ	29b. Signature and little of certifier			29	9c. License ni		0		ite signed (Month	
			30. Name and address of person who	us Po 13	08 17	pe, Print)	SKI	is one	y u	D	2180	2_
	* Sta		31. Date filed (Month, Day, Year)	32. Registrar	s Signature	W.						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 01 Physician 15 ŽÔĨO Holl, Sr. 10:30 Thomas /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bel Air Harford 2819 Henley Drive If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 03/12/1957 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 ☑ M 2 ☐ F Maryland 212-70-9474 52 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylai Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Madical Examir or must be notified at 1 ☐Yes 2 No Director Bel Air Harford MD 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 21015 U.S.A. 2819 Henlev Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 ☐Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 XNo þ Specify: White 3 Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Liquor Distributor Warehouseman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Holl, Sr. Doris Keenan ပ Edward 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3024 N. Calvert Street, Baltimore, MD 21218 Edward J. Holl, Jr., Brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Parkwood Cemetery 01/19/2010 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Leonard J. Ruck, Inc. 5305 Harford Road, Baltimore, MD 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the notice of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final E50 **Physician** disease or condition resulting in death) /Medical Due to (or as consequence) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine requires that the death certificate be executed burial-trar Due to (or as a consequence of): P.O. Box 68760, physician the burial Physician/Medical attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Vear 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 ◯ No has page 2 autopsy certificate | 2)X No 1 ☐ Yes 2 X No To the Hospital or Attending Physician: 25. Was case referred to medical director Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Medical Certification: To funeral Date of Injury (Month, Day, Year) 27. Magner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature at itle of certifier MT

State Registrar 31. Date filed (Month, Day,

🔊 Name and address of person who completed cause of death (Item 23a) (Type, 🖣 rint)

Year)

33 N

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. / 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** S:001 Susanne B. Howard DANUAD 182010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Cockeysville 9610 Labrador Ln. If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
Months | Days | Hours | Min. | (Month, Day, 5. Social Security Number 9. Birthplace (State or Foreign Country) California 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🕱 F 214-30-2531 77 Yrs. Director 12/14/1932 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the "Moderal Examiner must be notified at Baltimore Md Cockeysville Director 1 ☐Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9610 Labrador Ln. 21030 USA Funeral hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐Yes 2 No ģ Specify. Specify: White 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry within 72 h Elementary/Secondary (0-12) College (1-4or 5+) Housewife Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be f and Mental I permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic ev Robert E. Berry Myrtle Margaret Graham 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16339 Old York Rd Monkton, Md. 21111. Margaret Maher(Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State All County Cremation 01/20/2010 Sykesville, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Haight Funeral Home & Chapel P.A. 21784 6416 Sykesville Rd. Sykesville,Md 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 60 disease or condition resulting in death) /Medical (or as a consequent Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine to (or as a consequence on The law requires that the death certificate be executed physician a s the burial-1 Due to (or as a consequence of): Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🔲 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Dav 5 ☐ Other (specify) been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 No 24a. Was an certificate has autopsy performed? Yes 2 No page 1 🗆 Yes After this certification, I 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death
1 Natural
2 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation ours after death.

neral Director: A
filled in by the fu 1 ☐ Yes 2 ☐ No 6 ☐Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 24 hours 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

— Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) ical

Baltimore, Maryland 21215-0036

Box 68760,

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Division of Vital Records,

or Attending Physician:

Hospital

To the within 2

Registrar DHMH 17 Rev 1/2001

State

completely

(Check only one)

30. Name and address

29b. Signature and title of certifie

ath (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Month Vondessa Howard ANUAR. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ALTIMORE CNPral 8. Date of Birth (Month, Day, Year) 08-01-85 If Under 1 Year | If Under 24 Hrs. | Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Months Days Hours 1 □ M 2 □ XE 24 220-08-9164 MD Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b County 10d. Inside City Limits Director XXYes 2 □ No MD NA Baltimore 10f. Zip Code 10e Street and Number 10g. Citizen of What Country? 1012 Stoddard Court 21201 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14 Race - American Indian Black, White, etc. African 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2X No 2 Specify: American 3 Widowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 12th Grade Housekeeping Boscov Dept. Store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Terry Wayne Howard Vondelier ၉ Kellv 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vondelier Kelly-Mother 1012 Stoddard Court Baltimore, MD 21201 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metro Crematory 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 K Cremation 3 ☐ Removal from State 01-26-10 Catonsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice 22. Name and Address of Facility Wylie Funeral Home P.A. N. Gilmor Street Baltimore, MD 21217 638 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Je minated disease or condition resulting in death) Due to (or as a consequence of): Seque highly list conflictions, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner CONGESTED Due to (or as a consequence of) Physician/Medical IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No 1 Yes 21 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Man of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 □Yes 2 □ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide

Hospital or Attending Physician; The law requires that the death certificate be executed P.O. Box 68760, Division of Vital Records, within 24 hours after deatl To the Funeral Director:

Funeral

Director

or items 23a or 28a-f show inver must be notified at

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s 1 and 2 should be fil f Health and Mental H tem 27 is marked ott

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permit. Page Department of Important: If any injury or

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attending physician for use as the buria

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After this

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Exa

The Medical

/ じがん キング トン Maryland 21215-0036

Baltimore,

Registrar

cal

29a, Certifier

(Check only one)

29b. Signature and title of certifier

30. Name and address of person

31. Date filed (Month, Day, 32. Registrar's Signature JAN 20

who completed cause of death (Item 23a) (Type, Print)

[Certifying Physician: Jo the pest of the knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

OMARYLAND GENERAL HOSPITA

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #5, per Fit G899 1/26/10/ TT
State of Maryland / Department of Health and Mental Hygiene? Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 05:00 ardemon narlie anuary 15 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death The Johns Hopkins Hospital **Baltimore City** 5. Social Security Number 0009 If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) 12-17-1938 Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral 1**X□M 2□F 260-62-009 Director GA Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Examiner must be notified at Director 1 Yes 2 □ No MD na Baltimore 10e. Street and Number 10f. Zin-Code 10g. Citizen of What Country? "natural", or items 23a or 1818 E. Oliver Street 21213 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene.
Int: If item 27 is marked other than "natural", or ite 1 Never Married 2 Married 3 Widowed 4 Divorced Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: <u>م</u> 1 ☐ Yes 2 X No Specify Black Completed the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 12th grade Disabled Disabled 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charlie Hardemon Addie West <u>.0</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joe Hardemon-Brother 1818 E. Oliver Street Balto, MD 21213 item 2 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Pages
Department of
Important: If it
any injury or o 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place)
Cedar Hill Cem 1-20-2010 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March East F/H Q 1101 E.North Avenue Balto, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 1emorrhagi disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence ory: or Attending Physician: The law requires that the death certificate be executed the burial-trai Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Pregnant at time of death Day Year 5 Other (specify) 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 🗌 Yes 2 🗌 No 1 Tes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient 1 Yes 2 No Other: 4 \(\sum \) Nursing Home 2 - ER/Outpatient 3 🗆 DOA မ 5 Residence Director; After this d in by the funeral d 6 Other (Specify) 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred 5 Pending investigation Injury death. 2 Accident 1 Yes 2 No 3 Suicide Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide hours after City or Town, State) within 24 hours aft

To the Funeral Di

completely filled in To the Hospital Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

end manner stated. one) 29b. Signature and the of certifier 29c. License number 29d. Date signed (Month. Dav. Year) RES-OOD January 15 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St, Baltimore, MD, 21287 32. Registrar's State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 00943 State of Maryland / Department of Health and Mental Hygien Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 15 A /Medical not institution, give street and number 4c. County of Death 4a. Facility Name (If 4b. City, Town or Location of Death **Examiner** If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** Months 1 2 M 2 □ F Days Hours Min. Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10a. State or 28a-f show 10d. Inside City Limits traumatic event, the Medical Examinar hust be notified at Director d⊒Yes 2 No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐ No 'natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. filed within 72 hours after 1 □Yes 2 □
If Yes, Give
Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 ☐ Wo Specify: 2 Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) than " Pages 1 and 2 should be filed withir nent of Health and Mental Hygiene. Elementary/Segondary (0-12), College (1-4or 5+) permit. Pages 1 and 2 should be filed wir.
Department of Health and Mental Hygien Important: If item 27 is marked other thr.
any injury or other traumatic event. In 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ 19a. Informati's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number City or Town, State, Zip Code) P Place of Disposition (Name cometery, crematory or oth 20a. Method of Disposition Date 20g. Location - City or Town, State 20b 1 Usurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signatu e of Funeral Service Li ensee 22. Name and Address of Facility MD DIS 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, suc Approximate Interval Between Onset and Death respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of: Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): P.O. Box 68760, Physician/Medical for use as the the aftending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) detached 9 Unknown ģ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown filled in by the funeral director, page 2 should Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No has autopsy performed After this certificate 1 □Yes / 2 12 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check or one) Hospital: Other: 4 \sum Nursing Home 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 □ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 2 Accident 1 ☐ Yes 2 No within 24 hours after deatl To the Funeral Director: 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one 29b. Signature and title of certifier 29c. License number 31322 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MADEN CHOICE CN. BALLO LD2/24 716 RADEFP 31. Date filed (Month, Day, Year) Registrar's Signature State JAN 20 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - State of Marylar Registrar	id / Dep $C\epsilon$	partment of H ertificate of D	ealth and M <i>eath</i>	ental Hyg	giene Reg. No. 201	0 00944
ı	Physicia	n/	1. Decedent's Name (First, Middle, Last)				2. Date of Dea Month	th	3. Time of Death
	Medic	cal	Paul E. Hardcastle		-		January		0 6:20 P M
	Examir	ier	4a. Facility Name (If not institution, give street and number) Shady Grove Adventist Hospita	1	4b. City, Town, or I	Location of Death Ville		4c. County of E	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs.	If Under 24 Hrs.	8. Date of Birth	1 9.	Birthplace (State or Foreign		
	Director		268-34-0993 1 ★ 2 ☐ F 71 Usual Residence of Decedent	Yrs.	Months Days	Hours Will.	(Month, Day August I	4,1938	Cou <i>ntry)</i> Ohio
	and show	힏		ty, Town or Lo	ocation				10d. Inside City Limits
	Maryl 28a-f otifie	irec	Maryland Montgomery		Rocky	ville			1 🔀 Yes 2 🗌 No
	ith the	ra D	10e. Street and Number		10f. Zip Code			10g, Citizen of What	
	eath w	Funeral Director	9701 Veirs Drive 11. Marital Status 12. Was Decedent Ever in U.	S. 13.	Was Decedent of His	20850 panic Origin? (Spec	ify Yes or No-	United S	tates American Indian,
Maryland 21215-0036	ırs after de ural", or it I Examine	ξ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates.		If Yes, specify Cuban.	, Mexican, Puèrto R Specify:	ican, etc.)		Vhite, etc.
<u>.</u>	72 hou "nat	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Dece (Give	edent's Usual Occupat kind of work done du	tion Iring most of working	g	16b. Kind of Busine	ess Industry
212	vithin jiene. er thar the M		Elementary/Seconday (0-12) College (1-4 or 5+)	Chie	e kind of work done du DO NOT use retired) f Financia utive Vice	1 Officer	i.	Manufac	turing
2	filed tal Hyg	To Be	17. Father's Name (First, Middle, Last)			18. Mother's Name	(First, Middle, N	Maiden Sumame)	
<u> </u>	d Men marke matic	-	Edward Hardcastle 19a. Informant's Name/Relationship (Type, Print)	1			Mullins		
, Na	nd 2 sho ealth an m 27 is ier traui		Kerry Blair/Daughter		ing Address (Street an 00 Highlan				aryland 20854
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)	cometery, cre odland netery	osition (Name of matory or other place)	2010	ry 19,	20c. Location - City Dayton,	Ohio
gal	permit Depart Impor any in	12.	21. Signature of Funeral Service Ucensee M01498	B B	2. Name and Address ethesda-Ch	of Facility Robered Chase	ert A. I	Pumphrey 7557 Wi 501	Funeral Home/ sconsin Ave.,
			23a. Part 1. Enter the disease, or complications that caused the deat shock, or heart failure. List only one cause on each line.	h. Do not enf	ter the mode of dying,	, such as cardiac or	respiratory arre	st,	Approximate Interval Between
_	Ph_sician/ Medical	6 (1)	Immediate Cause (Final disease or condition resulting in death) Respirator		lure				Onset and Death
	Examiner		Due to (or as a conseq						
-	p #	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	uence of):					
	cate be executed physician and the burial-transit		Cause (Disease or iinjury that initiated events c. Due to (or as a consequence of the consequence)	uence of):					
20	ite be e hysicia he buri	edical	d						
200	ertifica ding pl		IF FEMALE: 23c. If yes, outcome of pregnant 23c. If yes, outcome of pregnant	nev			-		
POX	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Live Birth 2 Feet 1 Ves 2 No 9 Unknown 9 Unknown	al death 3	Ectopic pregnancy Other (specify)			23d. Date of Month	delivery Day Year
7. O	s that t gned b be deta	by	Part II. Other significant conditions contributing to death but not res	ulting in the I	underlying cause give	n in Part I.			e to the cause of death?
ecords,	require been s hould	eted	Pancytopenia						Probably 4 Unknown
Hecc	: The law ficate has l r, page 2 s	Completed	25. Was case referred to medical				24a. Was ar autops perforn 1 Yes 2	y prior ned? death	eautopsy findings avallable to completion of cause of n? Yes 2 \(\sumbolearrow\) No
NIT S	/siciar s certif	To Be	examiner? 1 Yes 2 XNo Hospital: 1 Xinpatient 2	EP/Outpatia	Other:	e of Death (Check o			*
5	ing Phy ofter thi		27. Manner of Death 1 □XNatural 5 □ Pending (Month, Day, Year)	28b. Time of injury				nce 6 Other (Sp w injury occurred	ресіту)
SION	uttendi death stor: A y the fu	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	me form et	M 1 □ Y€	es 2 No	Y 1 - 11 - 12 - 12		
DIVISION OF	Ital or A		4 - Homicide determined building, etc. (Specify		leet, factory, office		City or Town		Rural Route Number,
	the Hosp hin 24 hou the Funer upleted fil	Medical	29a. Certifier (Check children in the best of my known only one) 1 ★ Certifying Physician: To the best of my known in the basis of examination only one) 1 ★ Certifying Physician: To the best of my known in the basis of examination only one)	n and/or inves	stigation, in my opinion	death occurred at the	e time date and	d place and due to the	he cause(s) and manner stated
	5 ₩. 1		29b. Signature and title of certifier		29c. License n	10 68080	29	9d. Date signed (Mo	
	9/		30. Name and address of person who completed cause of death (Item Sireesha Jalli, 9901 Medical C	, , , , ,	Print)		Marylan		
	Stat	6	31. Date filed (Month, Day, Year) 32. Fegistrar's Signat	ure	bilve, ROC	CKVIIIE,	riai y Lan	u 20030	
	Registra		JAN 2 U 2010 Severe	14. 14					

Certificate of Death

2. Date of Death Month

Year

2010

n/a

4c. County of Death

USA

Domestic

23d. Date of delivery

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

2010

Month

14. Race - American Indian,

specify: African-American

08-41AM

Birthplace (State or Foreign Country)

MD

10d. Inside City Limits

Approximate Interval Between Onset and Death

YEELVS

ea. VS

1X Yes 2 No

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

82. Registrar's Signature

31. Date filed (Month, Day, Year)

JAN 20 2010

1. Decedent's Name (First, Middle, Last)

Doris A. Johnson

Physician

/Medical

Registrar DHMH 17 Rev 1/2001

State

GIZAW WOLDEHINOT, MD LEVINDALE, 2434 W. BELVEDERE AVE, BALTIMON 21215

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 1.5:45 M Medical Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 ■ M 2 □ F Months Days Hours Min. Country) Director Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10c. City, Town or Location with the Maryland event, the Medical Examiner must be notified at Director 1 Yes 2 ☐ No 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? Funeral items 23a 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 11. Marital Status Race - American Indian, Never Married 2 Married Armed Forces?
1 ☐ Yes 2 No Yes, specify Cuban, Mexic Black, White, etc. ō ģ within 72 hours after Maryland 21215-0036 Specify 1 Yes 2 No Specify: If Yes, Give Year or Dates. "natural", Completed 3 Widowed 4 Divorced 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) とろえ Be Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ and 2 should be Health and Menta traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Repermit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other tra Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Teremation 3 Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility orth 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and leath Immediate Cause (Final Physician/ Cardiovascular disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner five year Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or a Coronary atherosclerosis burial-transi that initiated events resulting in death) Last Due to (or as a consequency of): attending physician I for use as the buria Physician/Medical e Hospital or Attending Physician: The law requires that the death certificate be a 24 hours after death.

Puneral Director: After this certificate has been signed by the attending physicia leted filled in by the funeral director, page 2 should be detached for use as the hur Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Month Pregnant at time of death 5 Other (specify) Dav Year 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3. ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed 2 No 1 Yes 25. Was case referred to medica Division of Vital Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 🗌 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manne f Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred iniury atural 5 Pending work? Accident
Suicide 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 To the land within 2 only one) 29b. Signature and title of 29c. License number 29d. Date signed (Month. Day, Year) D0058860 JAN 18, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTO, MD

DHMH 17 Rev 7/2009

State

Registrar

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31. Date filed (Month,

e filed (Month, Day, Year)
JAN 20 201

DHILLON

MD

32. Registrar's Signatur

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CALVERT ST, suitesss

Amend 10b, 20a-c, 22, per Fh G899 1/21/10 TT To State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 00947 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 1/23 a M 2. Date of Death **Physician** Month Year Tanuary Paulette Jones 2016 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b_City, Town, or Location of Dea 4c. County of Death Tary land MOSP tal General Baltimore Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Oct 5, 1953 Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 💢 F Min 214-64-9214 **Director** Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location tof Health and Mental Hygiene.
If item 27 is marked other than "natural", or items 23a or 28a-1 snow or other traumatic event, the Modical Evaniner must be notified at 10d. Inside City Limits MD Funeral Director N/A 1√2 Yes 2 □ No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 410 W. Franklin Street 21201 filed within 72 hours after death USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: δ 1 ☐ Yes 2 No Specify. 3 Widowed 4 Divorced Specify: black Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) none none 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental David Lewis Jones Novella Stukes ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and:
Department of Health
Important: If item 27
any Injury or other tn
once. Ha-Zell Jones/niece 1103 Whatcoat Street Baltimore, MD 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State in state Greenmount Crematory 1/19/2010

22. Name and Address of Facility Joseph 1.

State Anatomy Board 655 4 □ Donation 5 ₩ Oth Baltimore MD Russ F.H. 2222 W. North Ave. re Funeral Service Ronal d ice Licensee Signa Board 655 W 21201 21216 mn Baltimore Street Baltimore, MD 23a. Palt 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** neumonia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner -mmunus Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last e to (or as a consequence of): Physician: The law requires that the death certificate be executed burial-transit Exami mmunda and ue to (or as a consequence of) physician sthe burial Box 68760, Physician/Medical attending p IF FEMALE yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day 5 ☐ Other (specify) Records, P.O. ned by the I∐Yes 2∐No 9 Unknown 9 Unknown signed by I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ icate has been signated by page 2 should b Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Jonknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? certificate Division of Vital 1 ☐ Yes 2 ☐ No 1 ☐ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To 27. Manner of Death 28a. Date of Injury After t 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural (Month, Day, Year) 5 | Pending To the nospressive death.

To the Funeral Director: Aff investigation 2 Accident 1 ☐Yes 2 ☐ No 3 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD magheter 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Maryland Corneral Hospi omashekar, m.d. 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 00948 State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2010 Month Yulanda Desirae King 7:11 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Co. <u>Gilchrist Hospice</u> Towson Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🔀 F Days Hours Min. 0470971969 Director Maryland 218-90-2085 40 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be marked once. 10a. State 10b. County Director 10c. City. Town or Location 1 Yes 2 X No MD Owings Mills Baltimore Co. 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 9107 Shireoaks Way 21117 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 X No
If Yes, Give Black, White, etc. þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Completed 3 🗌 Widowed 4 🗆 Divorced Specify: Year or Dates Black 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Grade Olan Mills Studio Photographer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Scott R. King Mary 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u> Katia King(Sister)</u> 9107 Shireoaks Way, Owings Mills, MD 21117 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) OSEDN BROWN F/H IND Crematory 1 Durial 2 Cremation 3 Removal from State ☐ Donation 5 ☐ Other (Specify) 02/01/10 Signature Uneral Service Licenses ²² Name and Address of Facility
Joseph H. Brown Jr. Funeral Home
2140 N. Fulton Ave., Baltimore, MD Fulton Ave., Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month signed by the a d be detached f 9 X Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 23e. Did tobacco use contribute to the cause of death? cate has been sig page 2 should b Completed 1 ☐ Yes 2 🗽 o 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? Yes Yes To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 200 Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 ther (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1/ Natural 28d. Describe how injury occurred injury 5 Pending Accident Investigation 1 🗌 Yes 2 🗆 No s after death Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours Medical 29a. Certifier ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) d title of certifie 29b. Signature 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2120 omi

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day,

2. Regis

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney 00949 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Date of Death Month 3. Time of Death Physician ANGELA B. KRAUS Year Day JAN. 2010 1:00P /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death OAK CREST CENTER PARKVILLE BALTIMORE Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1□M XXF Months Hours 215-44-0925 **Director 8B** 26, 1921 Perry Hall. Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County nal Hygiene. 3d other than "natural", or items 23a or 28a-f show event, the Peofical Evanting at motified at 10c. City, Town or Location 10d. Inside City Limits Directo 1 ☐ Yes 2 No Maryland Baltimore Baltimore County 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral BB00 Walther Blvd. Apt. 3212 21234 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Yes ※ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ģ 1 ☐ Yes 2√XNo Specify. Specify: White 3√Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Baltimore County Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiens Important: If item 27 is marked other that amportant: other traumatic event, Iral once. Bth grade N/A School System Cafeteria Worker 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) John Schott Carolyn Frisch ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol Rommal (Daughter) 14738 New Windsor Rd. New Windsor, Md. 21776 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State XXX Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Joseph Ch. Cem. 1~23~2010 Fullerton, Md. 22. Name and Address of Facility Lassahn Funeral 7401 Belair Rd. 21. Signature of Funeral Service Licensee Home Baltimore 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Alzhermers Disease /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) The law requires that the death certificate be executed burial-tra Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be exwithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the buria Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Cardiovascular Hypertensive 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 ☐Yes 2 ☐No 1 ⊟Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Certification: To Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Knows

State

Registrar

Medical

29a. Certifier (Check only one)

re and title of certifier

address of nerson who

CRAP, MSN completed cause of death (Item 23a) (Type, Print)

GAN, MIN

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number 2171944

8800 Walther Blad, Parkville MD 21234

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Year Paul Daniel Joseph Key 9:18 PM 2010 January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Agues Hospital Ralfimore Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1 M 2 □ F 216-20-7789 83 Director 4-12-1926 MD Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified anone. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 □ No Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1038 Brantley Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Tyes 2 No
If Yes, Give 1944-46 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 specify: African-American 1 □Yes 2 No Specify \$ 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Assembler General Motors 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Aubrey Key Mary Ruth Nelson ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sabree K. Akinyele/Daughter 1033 Brantley Avenue, Baltimore, MD 21217 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State Garrison Forest Veterans 1-26-10 Ovines Mills, MD 4 ☐ Donation 5 ☐ Other (Specify) 1. Signatur of Funeral Service Licensee 22. Name and Address of Facility Wille Puneral , time P.A. of Palto. Co. 9200 Liberty Road, Randallstown, MD 21133 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Grastro lytestinal /Medical Due to (or as a consequence of): 9 days **Examiner** Myocardial if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a conseq ence of): or Attending Physician; The law requires that the death certificate be executed Ischemia and burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician; the law hours after death, within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician in the funeral director, page 2 should be detached for use as the burial director. Physician/Medical Cardiogenic 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 🗆 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 □Yes 2 🗖 No 9 I Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Renal Failure 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 점 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 🗷 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ၉ 1 Yes 2 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) P23627 01-16-2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore 900 SRIKANTH PARST Coton Avenue

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

JAN 2 0 2010

32. Registrar's Signat

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ William E. Keith Sr. 201n 6:31 A. M January Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore Washington Medical Center Anne Arundel Glen Burnie Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1**X** M 2 □ F (Month, Day, Year) 03/11/1934 Hours Virginia 75 Director 223 42 3639 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director must be notified 28a-f N/A Baltimore 1 🏝 Yes 2 🗆 No Maryland 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 610 Arsan Avenue 21225 U.S.A. items "natural", or item ledical Examiner n Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Completed by 1 X Yes 2 □ No If Yes, Give Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 X Divorced White Year or Dates Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) MD Automatic Elementary/Seconday (0-12) College (1-4 or 5+) 6th Mechanic Transmission Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ William Keith Donna Daveda 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Anderson Baltimore, Maryland 21225 610 Arsan Avenue 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🙀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 01/22/2010 Baltimore, Maryland Cedar Hill Cemetery 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licensee 4001 Ritchie Highway Baltimore, Maryland 21225 eart 1. Enter the disease complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Pnysician/ PARDIO-RESPIR disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last signed by the attending physician and a be detached for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ TERLOSELE ROSIS 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law r within 24 hours after death.

To the Funeral Director: After this certificate has be this certificate has rail director, page 2 s performed 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 1 Yes ပ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 \square Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Effertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner; Jothe best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar egistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 20 | 0 0952

		1- For State Certificate of	Death	Reg. No.	
Physicia				Date of Death Month Day	3. Time of Death
al Exami	ner			January 10, 20	10
		idi i doniti i ilania (il ilania ilan	b. City, Town, or Location of Death Bahamas Baltimo	re 🔫	c. County of Death Out-Of-State N/A
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 122-24-8509 1X M 2 F 76 Yrs.	If Under 1 Year If Under 24Hrs Months Days Hours Min		VDD/YYYY) 9. Birthplace (State or Foreign Country) NewYork
		Usual Residence of Decedent			
ow any		10a. State 10b. County 10c. City, Town or Location NewYork Nassau Baldwin	on		10d. Inside City Limits 1 Yes 2 X No
yland a-f she	ector	10e. Street and Number	10f. Zip Code	10g. Cit	tizen of What Country?
vith the Maryland s 23a or 28a-f show a e notified at once.	Direc	1781 Harte Street	11510	U	.S.A.
215-0036 be filed within 72 hours after death with the Maryland ntal Hygiene. rked other than "natural", or items 23a or 28a-f shu ent, the Medical Examiner must be notified at once	neral	1 Never Married 2 V Married Armed Forces? If Ye	s Decedent of Hispanic Origin? (S es, specify Cuban, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
ter dea ", or i	, Fun	1 Yes 2 No	Yes 2 X No specify:		specify: White
ours af atural	b b	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent during me	's Usual Occupation (Give kind of ost of working life. DO NOT use ref		Kind of Business/Industry
11215-0036 Id be filed within 72 hours after Aental Hygiene. narked other than "matural", event, the Medical Examiner	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	/Brokerage		nsurance
-003 withingiene.	E	17. Father's Name (First, Middle, Last)		e (First, Middle, Maider	
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be C	Frederick Kopf		Ferulano	
e a se se se se se se se se se se se se se	[2	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing	Address (Street and Number or		
MC 2 slath at sm 27 raums			larte Street, E	Baldwin, N Date 20c	ew York 11510 Location - City or Town, State
S 1 S 1		1 37 Puriol 2 Cromation 3 Removal from State crematory or oth		15 10Fa	armingdale,NewYor
or ne		4 Donation 5 Other Specify: St. Charl 21. Signature of Funeral Service Licensee 22. N	lame and Address of Facility M	arzullo F	Suneral Chapel, P.
Balt permit. Departi Import		muchael Pramello 60	009Harford Ro	ad,Baltim	nore, Maryland2121
hysician		23a. Part I. Enter the disease, ox/complications that caused the death. Do not enter the failure. List only one cause on each line.		or respiratory arrest, st	hock, or heart Approximate Interval Between Onset and Death
Medical Examiner		Immediate Cause (Final disease or condition resulting in death) a Atherosclerotic Cardiovascular Disc	ease		
		Seguentially list conditions, b.			
	iner	D			
d d	Examine	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
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760, icate be ex physician the burial	Medical	IF FEMALE: 23c. If yes, outcome of pregnancy	r ME g899 1/20/1	2	23d. Date of delivery
687 ertifica ding pl		23b. Was decedent pregnant in the past 12 months?	stal death 3 Ectopic pregi	nancy	Month Day Year
Box 687 e death certifu the attending	vsic	1 Yes 2 No 9 Unknown Pregnant at time of ceath 5 Ot	her (Specify)		
~ ‡ ≥ 5	by Phy	Antony Discoso	underlying cause given in Part I.		o use contribute to the cause of death? No 3 Probably 4 Unknown
Ords, P.C. w requires that as been signed !				24a. Was an	24b. Were autopsy findings available
cord law rec has bee	_			autopsy performed	
Vital Reconysician: The law	5	OF Was and antiqued to modified	26.Place of Death (Chec	1 Yes 2	No 1 Yes 2 No
/ital sician: is certi	Be e	Hospital: 1 Inpatient 2 FR/Outpatient	Other:		idence 6 🗸 Other: Scene
n of V ding Phy After th	-	27 Manner of Death 28a, Date of Injury 28b, Time of		28d. Describe how i	injury occurred
ion trendir leath.	atio	1 V Natural 5 Pending 2 Accident Investigation	1 Yes 2 No	1 201 1 11 (0)	All who are Durel Doute Number City
Division of Vital Records, pital and Attending Physician: The law require unrafter death. After this certificate has been siftlied in hy the filterent about 5 should the stream of the pital of the pit	Certification	3 Suicide 6 Could not be determined (Specify)	et, factory, office building, etc.	or Town, State)	et and Number or Rural Route Number, City
id no le			irred at the time, date and place, a	nd due to the cause(s)	and manner as stated.
Division To the Hospital or Attent within 24 hours after death to the Funeral Director:	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation and manner stated.	ation, in my opinion, death occurred	d at the time, date and	place, and due to the cause(s)
F ≥ 5 5	ž Ž	29b. Signature and title of certifier	29c. License number	1	d. Date signed (Month, Day, Year)
		lalmer / ?	O.C.M.E.	Ja	anuary 11, 2010
		30. Name and address of person who completed cause of feath (Item 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 111 Per	nn Street, Baltimore, MD 2	21201	
_	Stat	e 31. Date filed (Month, Day (Sa)) 32. Registrar's Signature	hadel		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 201C PM RUTH MARTHA KIEGLER Medical വവാഗ 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death itizens ome 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Oct. 15 Security Number Birthplace (State or Foreign Country) **Funeral** If Under 24 Hrs 1 - M-2 TE Months Days Min. Yrs Director 205-10-6498 Pennsylvania Usual Residence of Decedent 10a. State 10b. County notified at 10c. City. Town or Location 10d. Inside City Limits Director 28a-f 1 🗌 Yes 2 🎛 No Colorado Bailey Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ıral", or items 23a o Examiner must be Funeral 342 Hall Road 80421 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 X No Specify Specify "natural" Completed 3 St Widowed 4 Divorced White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) of Health and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Food Service Public Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harry Nicholas Jones Martha Ann Sanderson traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 other tra Box 1167, Bailey, CO 80421 <u>Donald F. Kiegler Jr./ Son</u> Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State . Page 1 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Department o Important: If any injury or Bel Air Memorial Gdn 1-20-10 Bel Air, Maryland 4 ☐ Donation 5 ☐ Other (Specify) al Service 2. Name and Address of Facility CCOMAS Funeral Home, 317 Cokesbury Road, P.A. Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complication, that caused shock, or heart failure. List only one cause on each line. that caused the death. Do not enter the more of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Memous disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Dav Year 1 Yes 2 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has performed 1 🗌 Yes Yes 2 10 Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 1 🗋 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Hospital or Attending 1 Accident 5 Pending Investigation To the Hospital or Attend within 24 hours after death To the Funeral Director: / 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 🔀 ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOW 31. Date filed Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 24a, 26, 27, 28a-c, f, per doc 8890 1-20-10 vt State of Maryland / Department of Health and Mental Hygiene

		•	1 - State Registrar		Otato of f	viai yiai	•	tificate of I	Death	vicinairiy	Reg. No.	2010	00051
	Dhysisis	/	1. Decedent's Nam	e (First, Middle	. ,					2. Date of De	ath	2010	3. Time of Death
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€	Examin	er			give street and number)			r Location of Death	ı	4c. (County of Death	
	Funeral		5. Social Security N	Vareham umber	6. Sex 7. /	Age (In yrs. I	last birthday)	If Under 1 Year	dalk Tif Under 24 Hrs.	8. Date of Bir	th	9 Birth	ore Co.
	Director		215-44-0		1 □ M 2 🌠 F	64	Yrs.	Months Days	Hours Min.	Oct. I	2 , 194	5 Mary	Tand
	land show dat	٦٢	Usual Residence of 10a. State	Decedent 10b. County		10c. Cit	ty, Town or Loc	ation				1	0d. Inside City Limits
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	the N	I Di	10e. Street and Nur	nber				10f. Zip Code		1	10g. Citiz	en of What Cour	ntry?
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10	r deat or iter niner	MD Baltimore Baltimore 10e. Street and Number 1933 Wareham Road 11. Marital Status 12 Never Married 2 Married Married 12 Married 10e. Street and Number 1933 Wareham Road 11. Marital Status 12 Never Married 2 Married 12 Married 12 Never Married 2 Married 15 Never Married 2 Never Married				t Ever in U.S ? XNo	S. 13. V	las Decedent of H Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	1-	4. Race - Americ Black, White,	
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	and 2 Health em 27 ther t		Patrick 20a. Method of Disp		kins (Frier				s Ct. Be				014
Baltimore,	age 1 ent of nt: If it y or o		1 Burial 2	Cremation	3 Removal from Sta	te c	emetery, crem	sition (Name of atory or other place	orp. 1/18	Date		ation - City or To 780n,Ma	•
altir	permit. P Departme Importar any injur once.	- 5	21. Signature of Fu			Lutt			ss of Facility Funeral				
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			shock, or hea	rt failure. List o	complications that caus nly one cause on each li	ed the death ne.							Approximate Interval Between
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Y	cuted	xam	Cause (Disease or that initiated events	iinjury	c								
	tificate be executed ng physician and as the burial-transit	Medical Examiner	resulting in death) I	_ast	Due to (or a	s a consequ	ience of):						
8760	ificate I	l di			d				_				
9			IF FEMALE: 23b. Was decedent		23c. If yes, outcom			Ectopic pregnance			23	d. Date of delive	ry
Box	Physician: The law requires that the death cer this certificate has been signed by the attendiral director, page 2 should be detached for use	Physician/	in the past 12 r 1 ☐ Yes 2 E 9 ☐ Unknown		4 Pregnant	at time of d		Other (specify)	;y			Month	Day Year
P.O.	that the desired by the stacked is			icant condition	ns contributing to death	but not resi	ulting in the ur	derlying cause giv	ven in Part I.	23e Did to	pacco use	contributa to th	e cause of death?
S, F	lires the signer of the control of t	Completed by											ably 4 Unknown
Records,	w require s been s	plete								24a. Was a	an I	24b. Were autop	sy findings available
Rec	The law ate has page 2 :	E	-					-		autop perfoi 1 Yes	med?	prior to con death? 1 \(\sum \) Yes	npletion of cause of
ta	ysician: The iis certificate director, pag	Be	25. Was case referre examiner?		11				ace of Death (Chec		Z MESN INU	T Les	2 🗀 140
of Vital	Physical this caral dire	<u>۹</u>	1 ☐ Yes 2 € 27. Manner of Death	No	Hospital: 1 Inpa 28a. Date of in		ER/Outpatient 28b. Time of		4 Nursing Ho			Other (Specify)	
o u	Attending Ph or death. ector: After thi by the funeral	Certificate:	1 X Natural 2 Accident	5 Pending	(Month, D	ay, Year)	injury		yes 2 □ No	28d. Describe h		ccurred	
Division	I or Attender after deatl Director:	##	3 Suicide 4 Homicide	6 Tould n	ot be 28e. Place of In	jury - At hor	me, farm, stree	et, factory, office		28f. Location (S	treet and N	lumber or Rural i	Route Number,
<u>D</u>	ital or urs aft ral Dir lled in				5	tc. (Specify)	NA			City or Town	-		
	To the Hospital or / within 24 hours after To the Funeral Dire completed filled in b	Medical	(Check 2		Physician: To the best of caminer: On the basis of	examination	and/or investig	ation, in my opinio	 n. death occurred at 	the time date ar	nd place ar	nd due to the cau	ce(c) and manner stated
	To the I within 2 To the I complet		only one) 3 29b. Signature and t		Nurse Practioner: To the	e best of my	knowledge, de	29c. License				nd manner as sta signed (Month, D	
			1/ and	ratte	ou ruh			DOOG	9848		01/1	4/201	
	5			ss of person w	ho completed cause of	death (Item	23a) (Type, Pr	nt)	MD 212	7/	- t		
			Candra Wood		20 Campbe	rar's Signati		teMonsh	MUZIZ	- 06			
	State		. Date filed (Moth	INDO	2010 32. Halist	ıar s olgnati	ule /						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | 0 Certificate of Death

00955

Physician Medica Examine

Funeral Director

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician/ Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760

	State Registrar	Cei	rtificate of D			Reg. No.	0 00955		
in/	1. Decedent's Name (First, Middle, Last) Sheldon Largen				2. Date of Dea Month Januar	Day Yea	3. Time of Death 10:25 AM ^M		
cal ner	4a. Facility Name (if not institution, give street and number)		4b. City, Town, or I	Location of Death	Januar	4c. County of D			
	Gilchrist Hospice		Towson			Balti			
	5. Social Security Number 6. Sex 7. Ac	ge (In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birt	th a	Birthplace (State or Foreign		
	577-84-2816 Usual Residence of Decedent	61 Yrs.	Months Days	Hours Min.	Feb 22	Y, Year 948 M	1948 Maryland		
b	10a. State 10b. County	10c. City, Town or Lo	cation				10d. Inside City Limits		
ect	MD Baltimore	₁	lowson				1 ☐ Yes 2 😾 No		
₫	10e. Street and Number		10f. Zip Code			10g. Citizen of What			
era	720 Bosley Avenue		21204			USA			
Ē	11. Marital Status 12. Was Decedent Armed Forces?	Ever in U.S. 13. \	Was Decedent of His f Yes, specify Cuban	panic Origin? (Sper	cify Yes or No-	14. Race - A	merican Indian,		
Completed by Funeral Director	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X If Yes, Give Year or Dates.	No	1 ☐ Yes 2 🛣 No		noun, oto.)	Specify: W	hite, etc. h ite		
plete	15. Decedent's Education (Specify only highest grade completed)		dent's Usual Occupa kind of work done du		unk	16b. Kind of Busine	ess Industry		
Com	Elementary/Seconday (0-12) College (1-4 or 0	life D	O NOT use retired)	ming most of working	,g	lumbei	r mill		
Be	17. Father's Name (First, Middle, Last)			18. Mother's Name	(First, Middle,				
P	Dewey Largen				World	,			
	19a. Informant's Name/Relationship (Type, Print)					r, City or Town, State,	Zip Code)		
	Faye Largen/former spouse		Mt. Carme						
	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 🖾 Other (Specify) 1.n. State	, I	sition (Name of natory or other place)	Pate	20c. Location - City	r or Town, State		
	3mm//// MU	B	altimore.	MD 2120	1	. Baltimor	e Street		
ĺ	23a Part 1. Enter the disease, or complications that cause speck, or heart failure. List only one cause on each lin Immediate Cause (Final	d the death. Do not ente e.	er the mode of dying	, such as cardiac or	r respiratory arr	rest,	Approximate Interval Between Onset and Death		
	disease or condition	hcm/c a consequence of):	carca	myopa	Thy		Years		
<u>.</u>	Sequentially list conditions.								
mine	cause. Enter Underlying Cause (Disease or iinjury	a consequence of):							
al Exa	that initiated events c Due to (or as	a consequence of):							
edic	d.			-					
an/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome		Ectopic pregnancy			23d. Date of	delivery		
hysici	in the past 12 months? 1		Other (specify)			Month	Day Year		
Be Completed by Physician/Medical Examiner	Part II. Other significant conditions contributing to death t	out not resulting in the u	nderlying cause give	n in Part I.	\ \d		e to the cause of death? Probably 4 🗌 Unknown		
plet					24a. Was a	an 24b. Were	autopsy findings available to completion of cause of		
Con					perfor	rmed? death	n? Yes 2 □ No		
Be	25. Was case referred to medical examiner?			ce of Death (Check	only one)				
10	1 ☐ Yes 2 ☐ No 1 ☐ Inpati	ent 2 ER/Outpatien		4 L. Nursing Hor		lence 6 🗖 Other (Sp	pecify) NOSPLW		
cate	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation		28c. Injury a work? M 1 🗌 Y	es 2 🗆 No	8d. Describe h	ow injury occurred			
Certif	3 Suicide 6 Could not be	ury - At home, farm, stre c. (Specify)	eet, factory, office	2	28f. Location (S City or Tow	Street and Number or in, State)	Rural Route Number,		
Medical Certificate:	29a. Certifier 1/ Certifying Physician: To the best of (Check only one) 3 Certifying Nurse Practioner: To the	xamination and/or invest	tigation, in my opinion	, death occurred at t	the time, date ar	nd place, and due to the	ne cause(s) and manner stated.		
	29b. Signature and title of certifier		29c. License r			29d. Date signed (Mo	· · · · · · · · · · · · · · · · · · ·		
	30. Name and address of person who completed cause of d	leath (Item 23a) (Type, P	rint)			January	1 2010		
	AMON J. CHMUES M. 31. Date filed (Month, Day, Year)	G.701 N ar's Signature	· Charles	11 Jes	~50N	MP			
te ar	JAN 20 2010	S. Son							

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year ahart **Physician** ames 14, 2010 January 11:36 E /Medical Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner St. Agnes Hospital Baltimore 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1 3 M 2 □ F Director 114-03-5491 89 6. 1920 New York Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Director 1 ☐ Yes 21 No Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 1702 Park Grove Avenue Funeral 21228 12. Was Decedent Ever in U.S. Armed Forces? 1 ★ Yes 2 → No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc within 72 hours after 1 Never Married 2 T Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 X No. Specify: Specify: White 2 3 Widowed 4 Divorced marked other than "natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Salesman Banking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be 'nent of Health and Mental Henry LaHart Anna Murphy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 she Department of Health and Important: If Item 27 is many Injury or other traum Jean LaHart 1702 Park Grove Avenue; Catonsville, MD 21228 e of Disposition (Name of 20c. Location - City or Town, State Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Crest Lawn Mem.Garden 1/19/2010 Marriottsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke 21. Signature of Funeral Service License Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue: Catchsville, MD 21228 Approximate Interval Between Onset and Death 23a. Part 1. Enter the dise se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ca e on each line Immediate Cause (Final disease or condition resulting in death) **Physician** OCCI ninuces /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last physician at the burial-tr Due to (or as a consequence of): P.O. Box 68760, Physician/Medical attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month Day 5 ☐ Other (specify) signed by the 2 No 9 Unknown Part II. Other significant conditions contributing to death but pot resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ş 2 No 3 Probably 4 Unknown has been signed by 2 should by 1 🗌 Yes Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? s certificate ha 1 ☐ Yes 2 ☐ ₩6 1 ☐ Yes 2 🗹 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) hours after death.

Ineral Director: After this ce
y filled in by the funeral direc 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28b. Time of 28c. Injury at Work? 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral D completely filled i 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner state. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature 5100 of person who completed cause of death (Item 23a) (Type, Print) Catorsville eisin 700 31. Date filed (Month, 32. Re als Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #18 Per FH G899 1/22/2010 High Research Plant File Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ January William Lalush 2010 2:30 Рм Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Carriage Hill Nursing Center Bethesda 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** September 29 1 💢 M 2 🗆 F Months Days Hours Min. , 1922 Pennsylvania 87 188-12-8001 **Director** Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County and 2 should be filed within 72 hours after death with the Maryland F Health and Mental Hygiene. It marked other than "natural", or items 23a or 28a-f shoother traumatic event, the Medical Examiner must be notified at 10a. State 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 X No North Bethesda Maryland Montgomery 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral United States 20852 6505 Tall Tree Terrace 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 □ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Defense Aerospace Corporate Executive Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Justice Obuch Peter Lalush 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13112 Peach Leaf Place, Fairfax, Virginia 22030 Cathy Lalush /Daughter item 2 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of I
Important: If ite
any injury or ot 18 Burial 2 ☐ Cremation 3 ☐ Removal from State
 ☐ Donation 5 ☐ Other (Specify) January Gate of Heaven Cemetery Silver Spring, Maryland 2010 Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 letto Barne M01305 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ NEUMONIA disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) ng physician and as the burial-transit The law requires that the death certificate be executed Cause (Disease of linjury that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician hed for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 5 Other (specify) Pregnant at time of death detached 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ate has been signed page 2 should be def þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 Yes 2 No certificate Yes 2 No To the Hospital or Attending Physician: 1 within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending work 1 🗌 Yes 2 Accident 3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical 29a. Certifier The Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

Registrar
DHMH 17 Rev 7/2009

POX

10110 Molecular Drive, Rockville, Maryland 20850

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Truong Bao, MD
31. Date filed (Month, Day, Year)

00057124

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 2010 10:55AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examine 939 Valley n/a St. Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 □ F Months Days Hours 92 Dec.8,1917 **Director** 238-20-1781 N.C. Usual Residence of Decedent 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Exymprer must be notified at Baltimore MD n/a Director 1 XYes 2 □ No 10e. Street and Number 939 Valley St. 10f. Zip Code 10g. Citizen of What Country? 21202 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itel any Injury or other traumatic event, the Modical Exemina any Injury or other traumatic event, the Modical Exeminations. 1 Tyes 2 No
If Yes, Give 9 42 – 45
Year or Dates 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: ð Black 3 □Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) laborer Drum Factory 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Lewis Julia Brown ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 939 21202 Rosalee Lewis (daughter) Valley St. Balto, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial ☑ Cremation 3 ☐ Removal from State Baltimore National 1-25-10 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. So ature of Funeral Service Licensee 22. Name and Address of Facility Calvin B. Scruggs Funeral Home 1412 E. Preston St. Balto, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ARDIOVASCULAR DISEASE **Physician** /Medical Due to (or as a consequence of): Examiner PERTENSION Ecqueritially list our diffusion, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Exami attending physician and for use as the burial-trar Due to (or as a consequence of): P.O. Box 68760 by Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) signed by the a I∐Yes 2□No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. After this certificate has been sign funeral director, page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an 1 □Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 KResidence 6 Other (Specify) Hospital: Medical Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA nours after death.

neral Director: After this y filled in by the funeral di 28a. Date of Injury (Month, Day, Year) 27, Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Naturai 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral I

completely filled 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one)

DHMH 17 Rev 1/2001

State

Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

HANDRAKAL

JAN 20

10

29c. License number

145244

29d. Date signed (Month, Day, Year)

GREENE STIBALTIMORE, MD-21201

and manner stated.

30. Name and address of person w o completed cause of death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year **Physician** William Townley Lemly 16, 10:15 P^M January 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 276 Wakely Terrace Bel Air Harford If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Days Hours Min. (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** 1 ★M 2 ☐ F Director 88 562-26-5759 July 21, 1921 North Carolina Usual Residence of Decedent filed within 72 hours after death with the Maryland r 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? De d "natural", or items 23a edical Examiner must b 276 Wakely Terrace 21014 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: ģ Specify. 3 Widowed 4 Divorced White Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. other than Elementary/Secondary (0-12) College (1-4or 5+) Sheet Metal Model Maker 12 U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ages 1 and 2 should be fill out of Health and Mental Hit: If item 27 is marked oth y or other traumatic eventy Be Harris Henry Lemly ပ္ Annie Belle Cook 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Virginia D. Lemly / Wife 276 Wakely Terrace, Bel Air, MD 21014 Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages nent of ! 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department o Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) Bel Air Memorial Gdn. 1-20-10 Bel Air, Maryland 21. Signature Funeral Service Licensee 22. Name and Address of Facility
McComas Funeral Home, P.A.
1317 Cokesbury Road, Abingdon, MD 21009 athleer Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a, Part1. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 15chemic Cerdiamyo poth GARAS Medical Due to (or as a consequence of): Examiner Heart Yen-s Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequency of Examiner The law requires that the death certificate be executed ASCU O Yeles and burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical 1+ TH IF FEMALE: for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Chronic Kidney disease 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Completed page 2 should Anemic 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No dianhea Chronic 1∐ Yes 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 N Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending Injury 1 Natura! 5 Pending 1 Yes 2 No investigation 2 Accident after death 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a e Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only one) and manner stated. within 24 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 1/15/10 D 3/295 MO 30. Name and address of person who compreted cause of death (Item 23a) (Type, Print) Kenwood Are Wandy KI
31. Date filed (Month, Day, Year) KIUESZ 21206 MO 5701 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

10-00460 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Shirley Juanita Marsh State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Juanita 0832 hrs Shirley Marsh Medical Examiner January 16, 2010 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Carroll Hospital Center Westminster Carroll 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Foreign Country) VA Months Davs Hours 230-68-1846 Director May 15 1950 59 1 M 2X F Yrs Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a State 10b County Ę is 23a or 28a-f show be notified at once. MD Carroll Svkesville 1 Yes 2 X No or 28a-f show hours after death with the Maryland Director 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 21784 USA 7371 Gaither Road 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12 Was Decedent Ever in U.S. 14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? White, etc. 1 Never Married 2 X Married Yes 2 X No white 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: ģ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed altimore, MD 21215-0036 rmit. Pages I and 2 should be filed within 72 hou spartment of Health and Mental Hygiene. prortant: If item 27 is marked other than "mat ury or other traumatic event, the Medical Exa during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) hospitality hotel manager 12 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pansy Showalter Be Charles William Kidwell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7371 Gaither Rd., Sykesville, MD 21784 Mr. Carl Neal Marsh (spouse) 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition Date crematory or other place) 1 Burial 2 Cremation 3 Removal from State 1 - 20 - 10Sykesville, MD All County Cremation Donation 5 Other Specify: 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licensee Page Spaight Herbert P.O. Box 195 Sykesville, MD 21784 23a, Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line Between Onset and /Medical Death Cardiac arrhythmia Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Cardiomegaly Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed and Physician/Medical X UNPENDED AMENDED attending physician or use as the burial PI line a-b, 27, per ME g900 2/4/10 TT Division of Vital Records, P.O. Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery 3b. Was decedent pregnant in the Day 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 V No 9 Unknown 9 Unknown signed by the a 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 ✓ No 3 Probably 4 Unknown 24a Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? 1 🗸 Yes ✓ Yes 2 No 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 🗸 ER/Outpatient 3 🔲 DOA Other Nursing Home 5 Residence 6 Other 1 Yes 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 X Natural 1 Yes 2 No Pending Investigation Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 6 Could not be Suicide or Town State) Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 💓 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and titl 29c. License number 29d. Date signed (Month, Day, Year) 50K O.C.M.E. January 17, 2010 aller 30. Name and address of person who completed cause of death (Item 23a) Victor Weedn MD JD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 32. Registrar's Signature 31. Date filed (Month) State Registrar

OGME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of Marylar	nd / Depa Cer	artment of I tificate of I	Health and I Death		-	10 00961
	Planaiaia		Registrar 1. Decedent's Name (First, Middle, Last))		uncate or .	Jean	2. Date of De		3. Time of Death
	Physicia Medio	al		tty	Moo			Month 1	9 20)10 5:10 P _M
	Examin	er	4a. Facility Name (if not institution, give s				r Location of Death		4c. County o	of Death
	Funeral		5. Social Security Number 6. Se	TM 2 FLE	**	Ralti If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da		Birthplace (State or Foreign Country)
	Director		144-40-4698 Usual Residence of Decedent	X 63	Yrs.			12-6-		MD
	yland f shov ed at	tor	10a. State 10b. County	10c. Ci	ty, Town or Loc	cation				10d. Inside City Limits
	r 28a- notifie	Direc	MD r	na B	altimo	ne 10f. Zip Code			10g. Citizen of W	1 🂢 Yes 2 □ No
	with the same same same same same same same sam	Funeral Director	4342 Nicholas	a Avenue		21206	5		U.S.	
	death ritems iner m		11. Marital Status	12. Was Decedent Ever in U. Armed Forces?			lispanic Origin? (Sp an, Mexican, Puerto			- American Indian, , White, etc.
036	s after ral", o Exam	Completed by	1 ☐ Never Married 2 ☐ Married 3 😾 Widowed 4 ☐ Divorced	1 ☐ Yes 2 X ☐ No If Yes, Give Year or Dates.	1	☐ Yes 2 X XNo	Specify:		Specify:	Black
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212	ed within 7 Hygiene. other than ont, the M		Elementary/Seconday (0-12) 12th grade	College (1-4 or 5+)	life. Do	ONOT use retired) Self En			Child	d Care vider
nd	be filed within 72 hours after death with the Maryland ental Hygiene. ked other than "natural", or items 23a or 28a-f show ic event, the Medical Examiner must be notified at	To Be	17. Father's Name (First, Middle, Last)				18. Mother's Nam	, , ,	Maiden Surname)	
Maryland	should be file and Mental is marked of raumatic eve		Thomas Taylor 19a. Informant's Name/Relationship (Type)	ne. Print)	10h Mailin	a Addross (Stroot	Cather	ine Mu		ato Zin Cadal
	ひかびゅ		Lisa Moore-dau			2 Ahern			MD 210	
Baltimore,	ge 1 and it of Heal if item 3		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □	20b. Removal from State	Place of Disponentery, crem	sition (Name of natory or other place 10rial I)) ₁ 1 1 5	Date 5-2010		City or Town, State
ļŧim	permit. Page 1 a Department of h Important: If ite any injury or ot		4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Fureral Service License			. Name and Addre				lstown, MD
ñ	Dep Imp any		Druf Mil				North		East F/ Balto	
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only on	e cause on each line.	4		1_	70		Approximate Interval Between Onset and Death
	Medical		Immediate Cause (Final disease or condition resulting in death)	a	uence of:	lled	rypert	ensia	1	3years
	Examiner	١	Sequentially list conditions,	b. ====						
	ed sit	Examiner	if any, leading to infinediate cause. Enter Underlying Cause (Disease or linjury	Due to (or as a conseq	uanda oly:					- 2
D,	execut an and rial-tra	l Exa	that initiated events resulting in death) Last	Due to (or as a conseq	uence of):					
760	sate be executed physician and the burial-transit	edical	•	d						
687	certific nding p	n/Me	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregna		1 -			23d. Date	of delivery
Box 68	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/M	in the past 12 months? 1 ☐ Yes 2 ②No 9 ☐ Unknown	1 ☐ Live Birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown		Ectopic pregnand Other (specify)	У		Mont	
P.O.	at the ed by t detach		Part II. Other significant conditions co	ntributing to death but not re	sulting in the u	nderlying cause gi	ven in Part I.	23e. Did to	obacco use contrib	oute to the cause of death?
ds, F	quires t	ed by		ctient failed		naintai			Yes 2 ☐ No 3	3 🗌 Probably 4 🗯 Unknown
Cor	law rec nas bee e 2 sho	Completed	routine to	llow up p	lans -	for hype	rtension	auto	osy pr	ere autopsy findings available ior to completion of cause of
l Re	siclan: The la certificate ha rector, page		25. Was case referred to medical			00.00	ace of Death (Chec	1 🗆 Yes		eath? □ Yes 2 No
Vita	nysicia iis certi directo	To Be	eyaminer?	lospital: 1 ☐ Inpatient 2 💃	ER/Outpatien	LOth	er.		dence 6 Other	(Specify)
n of	Attending Physician: Treath. r death. ctor: After this certifica y the funeral director, p		27. Manner of Death 1.★Natural 5 □ Pending	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury work M 1 🗆	y at ?? Yes 2 🗆 No	28d. Describe h	ow injury occurred	1
Division of Vital Records,	Attender deat ector:	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he			tes 2 LI No			or Rural Route Number,
<u>≥</u>	oital or urs after rral Dir			building, etc. (Specif				City or Tow		
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	Medical	(Check 2 Medical Examin	cian: To the best of my know er: On the basis of examination Practioner: To the best of m	n and/or invest	igation, in my opinio	on, death occurred a	t the time, date a	nd place, and due t	to the cause(s) and manner stated.
>°°	To the within To the comp	~	29b. Signature and title of certifier		,	29c. License			29d. Date signed (
				donald, my	220) /5: - 2	1)47	105		1/13/2	20/0
	4		30. Name and address of person who co	Simpleted cause of death (Item		It. no.	21236			
	Stat Registra		31. Date filed (Month, Day, Year)	32. Registrar's Signa						

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 7 per fh 8899 1-22-10 yt. State of Maryland / Department of Health and Mental Hygiene 2 0 1 0 00962 State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Menard Month 15:05 PM Tina 2010 Jan Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death University of Maryland Medical Center Baltimore N/A If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🎛 F Months Hours 0372871960 Maryland 216 84 0495 49 Director Usual Residence of Decedent or 28a-f show notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State hours after death with the Maryland Director 1 X Yes 2 No N/A Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō ed other than "natural", or items 23a o event, the Medical Examiner must be Funeral U.S.A. 628 Lucia Avenue 21229 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☑ No 1 Never Married 2 X Married þ ☐ Yes 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: 3 Widowed 4 Divorced White Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. Own Home Homemaker 7th permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, tt Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Thomas P. Candeloro Patricia Ann Dunn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Mooney III / Son 531 Maude Avenue Baltimore, Maryland 21225 Baltímore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Baltimore, Maryland Bayview Crematory 01/21/2010 4 Donation 5 Other (Specify) 21. Signatur Fyneral Service Linen 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part 1. Enter the disease, or complications that cause of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final NA. Physician disease or condition Zweeks **Medical** resulting in death) Due to (or as a consequence of): Examiner 2-4 weeks embol Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) 2-4 weeks or Attending Physician: The law requires that the death certificate be executed burial-transi Cause (Disease or iinjury Endocarditis and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria 20 years Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 \(\subseteq \) Yes 2 \(\subseteq \) No signed by the atte Month Dav 5 Other (specify) Pregnant at time of death g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medica 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: To 24 hours after death. Funeral Director: After this funeral (28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury 1 X Natural 5 Pending within 24 hours after death.

To the Funeral Director: Af completed filled in by the fu Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of 29c. License number Jan 18, 2010 NPI 1588899603 M 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 110 South Paca St. Emergency Medicine, 6th floor, Baltimore, MD 21201 Soudiago, MD Michael 31. Date filed (Month, Da 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ January Month Norma Lee Molloy 2010 Medical 4a. Facility Name (if not institution, give street and number Examiner 4b. City, Town, or Location Baltimore City, Town, or Location of Death 4c. County of Death Sinai Hospital of Baltimore Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth 1 □ M 2 🕱 F (Month, Bay, Year) y 18, 1935 219-32-8673 Hours Director 74 Tennessee May Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location the Medical Examiner must be notified at Director 10d. Inside City Limits Known as: Norma Molla Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a Funeral 1401 Adamsview Road 21228 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. ģ 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Completed 3 Divorced 4 Divorced 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) is marked other than Elementary/Seconday (0-12) 12 College (1-4 or 5+) Teller Banking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be find Health and Mental if item 27 is marked Charles Frederick McCoig Texie Mae Clevenger 19a. Informant's Name/Relationship (Type, Print, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lawrence Molloy Son 22314 N. 36th Street; Phoenix, Arizona 85050 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ō Important: If it any injury or o once. 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Phillips Cemetery 1/23/2010 Newport, Tennessee 22. Name and Address of Facility Sterling Ashton Schwab Witzke runeral Home of Catonsville, Inc. 21. Signature of Funeral Sept Co Lice LIC F MO1537 1630 Edmondson Avenue: Catonsville 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between
Onset and Death
3 Weeks Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Due to (or Examiner Cell Carcinona of the Luna 5 weeks amous Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine (or as a consequence of): the attending physician and hed for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 X No Pregnant at time of death Month Day 1 Yes 2 9 Unknown detached 9 🔲 Unknown hours after death.
hours after death.
hours after death.
ad filled in by the funeral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes ျ 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending (Month, Day, Year) 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) 24 hours 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ertifying Nurse Practioner: To the best of my knowledge within 2 To the I at the time date and place, and duc to the cauca(c) and intermer ac etated 29b. Signatur)e 29c, License number 29d. Date signed (Month, Day, Year) January _16,

5:40 P M

1 Yes 2 X No

DHMH 17 Rev 7/2009

State Registrar 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#5perFH, G900, 216/2010, WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ January 14, Day 2010 Year Mary Elizabeth Muldoon 12:20 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Montgomery Rockville Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛣 F Months Days Hours Feb. 13, ^Y1934 579-48-75 Washington, D.C. **Director** Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 ☐ No Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 874 College Parkway 20850 United States should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married <u>\$</u> Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give White Specify: Completed 3 Divorced 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation. 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Meginge. Elementary/Seconday (0-12) College (1-4 or 5+) Executive Administrative Assistant C.I.A. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Genevieve Shaw Joseph Muldoon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia A. Murphy/Sister 1830 Withmere Way, Dunwoody, Georgia 30338 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Ί̈́8, cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Jan. Mt. Olivet Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 2010 Washington, D.C. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert A. Pumphrey Funeral Home, Rockville, Inc. 300 W. Montgomery Avenue, Rockville, Maryland 20850 William a. Tun M01173 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Interval Between Onset and Death Years Immediate Cause (Final Physician/ Atherosclerotic Coronary Artery Disease disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Hypertension Years Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events and the burial-tran resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Day Year 4 Pregnant a Pregnant at time of death After this certificate has been signed by the funeral director, page 2 should be detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛛 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Yes 2 🗓 No Other: 욘 1 ☐ Inpatient 2 K ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at within 24 hours after death.

To the Funeral Director: After completed filled in by the funer 28d. Describe how injury occurred 1 X Natural (Month, Day, Year) injury 5 \square Pending work? 1 Tes 2 No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital o within 24 hours af To the Funeral Di Medical 🗓 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Certifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death backgrad at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 10069 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nicole Evancich, M.D.9901 Medical Center Drive, Rockville, MD 20850 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Reg. N	<u>, </u>	. U	1	U	U	U)	U
2. Date of Death	av.		Ye	ar	3. Ti	me d	of De	eath

Physician/	
Medical	
Examiner	ļ

Funeral

Director

show 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at filed within 72 tal Hygiene.

Baltimore, Maryland 21215-0036 Registered Nurse Be 17. Father's Name (First, Middle, Last) should be file and Mental F ris marked o ပ Mati Lal Sen Anupama 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Tapan K. Mukherjee / Husband 20a. Method of Disposition 20b. Place of Disposition (Name of Date 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) January 21 4 ☐ Donation 5 ☐ Other (Specify) Montgomery Crematorium, Inc. 2010 . Signature of Funeral Service Licensee M01305 aumie 23a. Part 1. Forer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Pulmonary Embolism disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** End Stage Renal Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of): that the death certificate be executed the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No signed by the at Id be detached fo P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ Division of Vital Records, Completed autopsy performed? Yes 2 No certificate 1 Yes the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) 2 X No Other: မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA After this 28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 1 X Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation 24 hours after deatl Funeral Director: completed filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined To the Hospital of within 24 hours a To the Funeral D Medical 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bindu Joseph, M.D. 31. Date filed (Month, Day State Registrar DHMH 17 Rev 7/2009 ORIGINAL

1. Decedent's Name (First, Middle, Last) Gouri Sen Mukherjee January 18, 2010 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery Hospice Casey House Rockville Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🛛 F Min. Year 929 Months Days Hours January 5 India 025-32-2869 81 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Montgomery Potomac 1 🗌 Yes 2 💢 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10608 Democracy Lane 20854 United States Was Deced Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married 1 ☐ Yes If Yes, Give 1 ☐ Yes 2 X No Specify: Specify: Asian Indian Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done of life, DO NOT use retired) (Specify only highest grade completed) during most of working Elementary/Seconday (0-12) College (1-4 or 5+) Nursing Home 18. Mother's Name (First, Middle, Maiden Surname) (unknown) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10608 Democracy Lane, Potomac, Maryland 20854 20c. Location - City or Town, State Bethesda, Maryland Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 Approximate Interval Between Onset and Death 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 4 □ Nursing Home 5 □ Residence 6 🖔 Other (Specify) Hospice 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, 1 XI Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the caus Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) January 18, 2010 6001 Muncaster Mill Road, Rockville, Maryland 20855

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 11:05 PM NAOMI VIRGINIA MARSH JANUARY 2010 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death STELLA MARIS HOSPICE BALTIMORE TIMONIUM 5. Social Security Number 7. Age (In yrs. last birthday) Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛛 F Days (Month, Day, Year MAR. 27, 1 Country) Maryland Months Hours Min. Director 215-07-4952 95 Ĩ914 Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 X No Maryland Harford White Hall 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2908 Troyer Road 21161 16, 2010 11:05 p.m. Maryland 21215-0036 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married If Yes, Give Year or Dates. 1 ☐ Yes 2 ☐ No Specify. Specify: Completed 3 ₩ Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Medical Receptionist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) Charles (unk) Scroggs Sr. Ida (nmn) Hobbs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna L. Sexton / Daughter 2908 Troyer Road, White Hall MD_21161 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1
Burial 2 Cremation 3
Removal from State Hilltop Service Corp 1-22-10 4 Donation 5 Other (Specify) Towson, Maryland 22. Name and Address of Facility McComas Funeral Home, P.A. uta of Funeral Service Ωcensee McComas Funeral Home, P.A.

1317 Cokesbury Road, Abinod

23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or help fail re. List only one cause on each line. 1317 Cokesbury Road, Abingdon, MD 21009 Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) a. CEREBROVASCULAR ACCIDENT Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of): Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical NAOMI MARSH Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 **X** No
9 ☐ Unknown Month Day Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 N 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 \square Nursing Home 5 \square Residence 6 X Other (Specify) **HOSPICE** 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, (Check 3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 13/2010 157624

Registrar
DHMH 17 Rev 7/2009

State

TIMONIUM, MD 21093

2300 DULANEY VALLEY RD.

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CRNP

JENNIFER HAÚF,

31. Date filed (Month, Day, Year)

JAN 2 0

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

00967

Examiner

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyghen.
Department of Health and Mental Hyghen important: If item 27 is marked other than "hatural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at any Injury or other traumatic event, the Medical Examiner must be notified at

3altimore, Maryland 21215-0036

Physician /Medical Examiner

attending physician and for use as the burial-transit law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, ed by the a detached f s been signed by should be detact page 2 s this To the Funeral Director

Director BALTIMORE MD N/A 10e Street and Number 10f. Zip Code 21215 4216 LABYRINTH ROAD Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No ģ 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER 17. Father's Name (First, Middle, Last) SANDRA SINGER SAMUEL ပ 19a. Informant's Name/Relationship (Type. Print) NATHAN NEWER / HUSBAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) MOSES MONTEFIORE 1/19/10 21. Signature of Fune tal Service Acet 23a. Part1. Enter the disease, or completions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only or cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part IJ. Other significant conditions contributing to death but not established in the underlying cause given in Part I þ 1 Yes Completed 24a. Was an autopsy 2[25. Was case referred to medical examiner? Be 26. Place of Death (Check only one 1 Hepatient 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 29a. Certifier Medical (Check only one) 29b. Signature and title of certifie and address of person who completed calle of death (Item 23a) (Type, Print) san

2. Date of Death 3. Time of Death Month JA N Year 0510 2010 16 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death + HOSP. MO BALTIMORE N/A LEVINDALE COERMARIC HEBREW HEAUTH CENTER If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 MD 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Days Hours 1 M 2 F 81 218-26-3068 09/06 Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. Inside City Limits 1 MYes 2 □ No 10g. Citizen of What Country? USA 14. Race - American Indian Black, White, etc. Specify: WHITE 16b. Kind of Business/Industry OWN HOME 18. Mother's Name (First, Middle, Maiden Surname) ROTHMAN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4216 LABYRINTH ROAD, BALTIMORE, MD 21215 BALTIMORE, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 Approximate Interval Between Onset and Death 23d, Date of delivery Month Year Day 23e. Did tobacco use contribute to the cause of death? 200 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation in my opinion death accurred. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manifer stated. 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day,

JAN 20

Year!

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month George Michael Overton :56 AM Medical **Examiner** 4b. City, Town, or Location of Death 4c. County of Death If Under 24 Hrs. 8. Date of Birth Funeral 9. Birthplace (State or Foreign 1√ M 2 □ F 70 Months Hours Min 213 1064 52 sept. by Yar957 MD (Ountry) Director Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified 23a or 28a-f MD n/a Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1324 N. Kenwood Ave. 21213 USA items 2 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, ٥ Black, White, etc. 2 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give X 1 ☐ Yes 2 ☐ No Specify: Specify: Black 3 Widowed 4 Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b Kind of Business Industry (Specify only highest grade completed) per it. Page 1 and 2 should be flied within 72 Det artment of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, the Mex gone. Elementary/Seconday (0-12) College (1-4 or 5+) yrs. Counselor CHIMES 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Overton Mary Askew 19a. Informant's Name/Relationship (Type, Print)
Mary Overton (mother) Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
N. Kenwood Ave. Balto, Md. 21213 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1

Burial 2

Cremation 3

Removal from State 4 Donation 5 Other (Specify) Jan. 20, 2010 Balto, Md. GreenMount Crema. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Calvin B. Scruggs Funeral Home
1412 E. Preston St. Balto.Md. 23a. Part 1. Enter the disease, or complications that caused the th. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or a Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran that initiated events resulting in death) Last Due to (or a a consequence of attending physiclan Physician/Medical for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy
5 Other (specify) Pregnant at time of death Month Day Year the detached 9 Unknown þ signed b Part II. Other significant conditions contributing to th but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 MUnknown director, page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? Was an autopsy performed? 24a. Was an certificate has 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 No Other: ပ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) After this completed filled in by the funeral 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. M. nner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending Accident Suicide Investigation 24 hours after deatl 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined City or Town, State) Medical 🌣 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check the the 29b. Signature 29c. License number

Registrar

State

se of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 00969 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ William Eugene Polcsa Janth. Day 2010 Year 17 9:15am^M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death <u>Brighton Gardens</u> Columbia <u>Howard</u> Social Security Numbe 8. Date of Birth (Month, Day, Year) Funeral Age (In yrs. last birthday) If Under 1 Year 9. Birthplace (State or Foreign 1 XM 2 - F Min. Hours Country) Director Yrs. 067-24-0405 114/26 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland injury or other traumatic event, the Medical Examiner must be notified at Director 1 🗌 Yes 2 😾 No MD Howard Columbia 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7110 Minstrel Way 21045 USA 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces? 9 þ Black, White, etc. 1 Never Married 2 Married 1 Yes If Yes, Give 1 ☐ Yes 2 XNo Specify: "natural", Completed 3 √2 Widowed 4 □ Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha Draftsman General Dynamics 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ္ရ Bela Polcsa Ethel Kovacs 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sl Department of Health a Important: If item 27 is any injury or other tra <u> Charles Polcsa (son)</u> 15208 Falcon Bridge Terr. Potomac, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) National 1/21/10 Bourne, MA 22. Name and Address of Facility Chapman Cole & Gleason Service Licensee 475 Main St. Falmouth. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Essential Hypertension disease or condition vears Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): Cause (Disease or linjury that initiated events g physician and s the burial-trans Due to (or as a consequence of): resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No 4 Pregnant
9 Unknown Day Pregnant at time of death signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Chronic Kidney Disease 1 ☐ Yes XX No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate ha performed? Yes 2 X No 2**X X**No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) 4 Nursing Home 5 Residence 6 X Other (Specify Living Hospital: Other: 1 Yes 2 X No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide injury 5 Pending 1 Yes 2 No Investigation the 6 Could not be within 24 hours after de To the Funeral Directo completed filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number D56531 1/18/10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 7/2009

State

Li

JAN 2 0 2010

8600 Snowden River Pkwy #301 Columbia, MD 21045

Baltimore, Maryland 21215-0036

Box 68760 Records, P.O. Division of Vital

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Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND TTEM#31perDVR, G899, 1/20/2010, WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 201°Ö Rosie Etta Presbury 1:00 pM 9 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 318 S. Spring Court Baltimore na 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex **Funeral** 1 □ M 2√□ F Months Days Hours Min. (Month, Day, Year) 12-12-1928 **Director** 81 218-28-2519 MD Usual Residence of Decedent item 27 is marked other than "natural", or items 28a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Baltimore na 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 318 S. Spring Ct 21231 SA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married hours after Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: Black Completed 3 ₩ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry unk (Give kind of work done during most of working life. DO NOT use retired) 72 2 should be filed within 72 th and Mental Hygiene. T is marked other than "I" Elementary/Seconday (0-12) College (1-4 or 5+) <u>llth grade</u> <u>Housekeepina</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Silas Robinson Irene Travers 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sho Department of Health an Important; If item 27 is any injury or other trau once. 231 S. Spring Ct Balto, MD 21231 Christine Stubbs-daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) King Memotial Pk 1-14-2010 Randallstown, Donation 5 Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility March East F/H 1101 E. North Avenue Balto, MD 21202 23a. Prit . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, grock, or heart failure. List only one cause on each line. Approximate nterval Between Onset and Death Immi dia e Cause (Final Physician/ C 9 dise ise / r condition result in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Exami physician and the burial-transit Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 XNo Month Day Year 4 ☐ Pregnant at time of death g ☐ Unknown signed by the a g Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hypertension 1 Yes 2 No 3 Probably 4 Unknown 2 should 24b. Were autopsy findings available prior to completion of cause of death? Aortic Stenosis 24a. Was an after death.

Director: After this certificate has be in by the funeral director, page 2 s autopsy it upa cholestero lemia Anemia Yes 2 X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐XNo Hospital Other: ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred the Hospital or Attending 1 Natural 2 Accident injury work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation 2 Accident
3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined filled in within 24 hours a

To the Funeral Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completed (Check 29b. Signature and title of cert 29d. Date signed (Month, Day, Year) D0058735 1-13-2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EBMC AMOL AWAWALA (006 EAST FAGER ST BALtimore Awada EAGER 1000 EAST 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAN 2 0 2010 A. parl Registrar

10-00340 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Sigurds Andris Plato State of Maryland / Department of Health and Mental Hygiene 2010 1- For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day January 12, 2010 Medical Examiner 0912 hrs Sigurds Andris Plato 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 11301 Rockville Pike Rockville Montgomery 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** Months oreign Director Days Hours 577-19-5183 1 X M 2 F 23 May 31, 1986 Country) Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 X No : 23a or 28a-f show : notified at once, Maryland Montgomery Bethesda Pages 1 and 2 should be filed within 72 hours after death with the Maryland Director 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 5712 Bent Branch Road 20816 United States Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, marked other than "natural", or items cevent, the Medical Examiner must be Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Never Married 2 Married Yes 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: Specify: White 2 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 21215-0036 Salesman Retail 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Gustav M. Plato Rasma Bliksons of Health and Mental 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 item 27 is Gustav M. Plato/Father 5712 Bent Branch Road, Bethesda, Maryland 20816 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Date 20c. Location - City or Town, State crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Jan. 19, Rock Creek Cemetery 2010 Washington, D.C. 4 Donation 5 Other Specify 22. Name and Address of Facility
Robert A. Pumphrey Funeral Home, Rockville, Inc.
300 W. Montgomery Avenue, Rockville, Maryland 20850 21. Signature of Funeral Service Licen Millian Tompluces M01173 23a. Part I. Enter the disease, or complications that paused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval failure. List only one cause on each line Between Onset and /Medical Death Heroin and alcohol intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. Due to (or as a consequence of) Examine if any, leading to immediate course: Enter Underlying Course (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last andtransit The law requires that the death certificate be executed Physician/Medical X UNPENDED physician the burial AMENDED 23a,27,28a-f,per ME g899 1/28/10 TT Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth as t Fetal death 3 Ectopic pregnancy Month Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown P.O. Part II. Other significant conditions 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I þ 1 Yes 2 No 3 Probably 4 Unknown Completed Records, 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy certificate has death? performed? page ✓ Yes 2 No 1 🗸 Yes 26.Place of Death (Check only one) 25. Was case referred to medical Be Hospital: 1 Inpatient Other Nursing Home 5 Residence 6 Other: Scene 2 ER/Outpatient 3 DOA this 1 🗸 Yes No 28a. Date of Injury (Month, Day, Year) 27 Manner of Death 28b Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification 1 Natural 1 Yes 2 X No unknown 5 Pending Fd 1/12/10 Fd 9:00 am the 2 Accident Investigation filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 11301 Rockville Piker Rockville, MD

Hospital or Attending Physician: Division of Vital r death. Director: within 24 hours a To the Funeral I

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one)

(Check only

Medical

State Registra

Suicide

Homicide 29a. Certifier

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner

- IMO

and manner stated.

6 X Could not be

determined

O.C.M.E.

January 13, 2010

29d. Date signed (Month, Day, Year)

111 Penn Street, Baltimore, MD 21201

29c. License number

28e. Place of Injury - At home, farm, street, factory, office building, etc

found in restaurant

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

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onovan Phillips			e of Maryland / De			Hygiene		201	0 0097			
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Physicia ledical Examir		Decedent's Name (First, Middle,L						2. Date of De Month January		Year	3. Time of Death 0633 hrs	
redical Examin		Donovan C. 4a. Facility Name (if not institution,	Phillips give street and number)		4b. City. T	Town, or L	ocation of Dea	January a	8, 201	C. County of Death		
		Frederick Memorial Hos					ederic			rederick		
Funeral		Social Security Number 6.	Sex 7. Age (In	yrs. last birth			If Under 24H		Birth(MM	/DD/YYYY) 9. Birt		
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		Usual Residence of Decedent					<u> </u>	_'			"Virgini	
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hours natur Exami	힣	15. Decedent's Education (Specify	only highest grade complete		Decedent's Usual luring most of wor				16b.	Kind of Business/I	ndustry	
136 thin 72 hours afte te. than "natural" edical Examine	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)		strict							
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215 be file ital Hy ked o	Bec											
21 nould h d Mer is mar	٥	19a. Informant's Name/Relationship		19b	. Mailing Address	(Street	and Number o	r Rural Route Nu	ımber, C	ity or Town, State	Zip Code) 2179	
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f short other traumatic event, the Medical Examiner must be notified at once		Connie Philli									Maryland	
or Hez	- 1	20a. Method of Disposition 1 Burial 2 Cremation	3 Removal from State	cremato	f Disposition (Nan ory or other place))		Date	1	Location - City or		
Page ment tant:		4 Donation 5 Other Spec	ify:	Mt.Ur	nionCem		-	14-10			ville,W.V.	
Baltimore, ML permit. Pages I and 2 s Department of Health as Important: If item 27	4	21. Signature of Funeral Service Lic	ensee								Chapel, P. A	
Physician	\dashv	23a. Part I. Enter the disease, gr col	mplications that caused the c	death. Do not							yland21214 Approximate Interval	
Medical	- 3	failure. List only one cause on				,					Between Onset and Death	
aminer	-1	Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequer		0010						<u> </u>	
		Sequentially list conditions,	b									
	Examine	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a consequer c.	nce of):								
d d	اق اق	(Disease or injury that initiated events resulting in death) Last	Due to (or as a consequer	nce of):								
and and	₩ I		d									
	笝	UNPENDED			g899 1/2	20/10	TT		1			
(ecords, P.O. Box 68760, The law requires that the death certificate be exate has been signed by the attending physician age 2 should be detached for use as the burial	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 Live birth	pregnancy	Fetal death	3	Ectopic preg	nancy	23	d. Date of delivery Month	ay Year	
or use	sicia	1 Yes 2 No 9 Unkno	4 Pregnant at time	of death 5	Other (Spec	cify)			Ť			
that the deathed by the att detached for	된	Part II. Other significant condition	9 Offiction	not resulting	in the underlying	rause niv	ven in Part I	23e Did	tobacco	use contribute to	the cause of death?	
P.C s that	ক	Hypertensive atheroscle			and discorrying	oudse giv	voir in r une i.	1 Ye	_		ably 4 🗸 Unknown	
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tal Records tian: The law requirentificate has been		25. Was case referred to medical				26 Place o	of Death (Chec	1 Yes	2 N	lo 1 🗸 Ye	s 2 No	
n of Vital I ding Physician: After this certifi funeral director,	Be	examiner?	Hospital: 1 Inpatient 2	2 ✔ ER/Ou			Wher:	sing Home 5	Reside	ence 6 Other		
ling Phy After th	أظ	27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. T	ime of Injury	28c. Injury	at Work?	28d. Describe	how inj	ury occurred		
ion tendi cath. for: /	틽	1 Natural 5 Pending 2 Accident Investig				1 Ye	es 2 No					
Division of Vital Records, pital or Attending Physician: The law require ours after death. Beral Director: After this certificate has been signed in by the funeral director, page 2 should be a shou	Certification: To	3 Suicide 6 Could no	ot be 28e. Place of Injury -	At home, far	m, street, factory,	, office bui	ilding, etc.	28f. Location or Town,		and Number or Ru	ral Route Number, City	
ner ner y fill		4 Homicide determine	(Op cony)									
	Medical		ician: To the best of my knowner:On the basis of examination									
To T	Med	29b. Signature and title of certifier	and manner stated.	0		. License				Date signed (Mor		

State 31. Date filed (Month, Day, Year)
Registrar

30. Name and address of person who completed cause of death (item 23a)

Zabiullah Ali, M.D. Assistant Medical Examiner 11

ORIGINAL

O.C.M.E.

3a) 111 Penn Street, Baltimore, MD 21201

January 9, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Month **Physician** Januaru 18:47 4a. Facility Name (If not institution, give street and number) 2010 /Medical 4c. County of Death 4b. City, Town, or Location of Death **Examiner Baltimore City** The Johns Hopkins Hospital 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number Sex 1X M 2 □ F 7. Age (In yrs. last birthday **Funeral** 55 Maryland May27,1954 Director 222-40-2010 Usual Residence of Decedent 10d. Inside City Limits or 28a-f show notified at 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2X No Directo New Castle Newark Delaware 10f. Zip-Code 10g. Citizen of What Country? 10e. Street and Number 6 death with r items 23a or ner must be r 19711 U.S.A. 21 Fox Tail Court Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Examiner Pages 1 and 2 should be filed within 72 hours after 1 Yes 2X If Yes, Give Year or Dates: 2**X** No 1 Never Married 2 XMarried ò 1 ☐ Yes 2X No Specify: White <u>م</u> 3 Widowed 4 Divorced "natural" Completed 16b. Kind of Business/Industry d other than "natura vent, the Medical E 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Construction Self-Employed 12 event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ith and Mental F 27 Is marked ot traumatic even Isabel Thorn Owen Parks, Sr. ည 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 Is any injury or other trau once. 102 Duet Drive, Newark, Delaware 19713 Carli Parks 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Silverbrook Cemetery1-22-1QWilmington, Delaware 4 Donation 5 Other (Specify) 22. Name and Address of Facility Marzullo Funeral Chapel, P.A. 21. Signature of Funeral Service Licensee margulle michael ! 6009Harford Road, Baltimore, Maryland21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Due to (our s a consequence of): disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): The law requires that the death certificate be executed physician and resulting in death) Last Due to (or as a consequence of) Physician/Medical as attending | IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death Month Day Year in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) d by the al 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 □ No 2 No 1 Yes 1 Yes certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?
1
Yes Other: 4 \square Nursing Home Hospital: 2 No 1X Inpatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) မ funeral Time of 28c. Injury at Work? 28a. Date of Injury 28b. 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 2 Accident (Month, Day Year) After Injury s after dec. al Director: After 5 Pending 1 Yes 2 No investigation 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide filled 29a. Certifier (check only (Machifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical

Division of Vital Records, P.O. Box 68760. Hospital or Attending Physician: thin 24 hours a the Funeral D within 2 the

Baltimore, Maryland 21215-0036

Rina Knodn 31. Date filed (Month, Day, Year) 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar one)

29b. Signature and title of confiden

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s)

29c. License number

KESUCO

29d. Date signed (Month, Day, Year)

1/17/10

600 North Wolfe St, Baltimore, MD, 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Procession Control C	Leroy Priester		State of Maryland / Department of Health and Mental H 1- For State Certificate of Death		2010 0007
Security Name of Control Control (Control Control Co		n/	1. Decedent's Name (First, Middle,Last)	2. Date of Deat	h 3. Time of Death
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And the contribution of contributing to death but not resulting in the underlying cause given in Part I. And	ox 6 sath cert attendii	Sicia	past 12 months? 4 Pregnant at time of death 5 Other (Specify)		1
one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number O.C.M.E. 29d. Date signed (Month, Day, Year) January 17, 2010 30. Name and address of person who completed cause of death (Item 23a) Patricia Aronica-Pollak MD. Assistant Medical Examiner 31. Date filed (Month, Day, Year) 32. Registrar's Signature	O. B at the d d by the trached			23e. Did tol	bacco use contribute to the cause of death?
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Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 State 31. Date filed (Month, Day, Year) 32. Registrar's Signature		-	Fablica Wanila Tollaria		January 17, 2010
				re, MD 21201	
regional Man & Colo Carone R. Mande	Stat Registra	_	31. Date filed (Month, Day, Year) 32. Registrar's Signature		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Roberts Charles Bernard Month 2010 January 1:30 Α Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Co. Towson Gilchrist Hospice Center Social Security Number 8. Date of Birth
(Month, Day, Year)
Feb. 23,1919 9. Birthplace (State or Foreign Country) Virginia If Under 1 Year If Under 24 Hrs. **Funeral** Age (In yrs. last birthday) 1 XXM 2 - F Hours Min. **Director** 90 Yrs. 223-16-6846 Feb. show 10a. State death with the Maryland 10b. County iral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Dunda1k MD Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21222 1301 Willow Road United States 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 □ No If Yes, Give WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian "natural", or þ 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or 5-0036 1 ☐ Yes 2 No Specify: Completed 3 ☑ Widowed 4 ☐ Divorced Year or Dates. White other than "natu ent, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Maryland 2121 Elementary/Seconday (0-12) College (1-4 or 5+) Steel Industry Steelworker 3 Years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evonce. Minnie Bowles Charles Raymond Roberts 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1265 Willow Road Dundalk, Maryland Dorothy Steinacker (Friend) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 ☒ Other (Specify) Entombment Gdns. 1/22/2010 Middle River, MD Holly Hill Mem. 21. Signature of Funeral Service License 22 Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death mona Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions. Examine if any, heading to immedicause. Enter Underlying Due to (or as a ponsequence of): attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Ectopic pregnancy Pregnant at time of death Month Day Year signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 □ Probably 4 □ Unknown 1 🗌 Yes Completed After this certificate has been situated the funeral director, page 2 should Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No ျှ 1 Yes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Dother (Specify) HUS Pico Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 1 Natural 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 2 🗌 No Accident Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my kn wledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie annani, MC 0059 6 by 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month January 16 2010 Year Medical Delores E. Redman 7:17 p. M 4a. Facility Name (if not institution, give street and number) **Examiner** 4b City Town or Location of Death 4c. County of Death Baltimore Stella Maris Hospice Timonium Funeral Social Security Number 7. Age (In vrs. last birthday) 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 💢 F Months Hours Director 217-22-0297 MDUsual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location with the Maryland injury or other traumatic event, the Medical Examiner must be notified at Director 10d. Inside City Limits 1 Yes 2 □ No Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral "natural", or items 23a 1700 Meridene Drive, Apt. 309 21239 LISA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces 1 ☐ Yes 2 XNo If Yes, Give Black, White, etc. 1 Never Married 2 Married Completed by 3altimore, Maryland 21215-0036 should be filed within 72 hours after 1 ☐ Yes 2 🎇 No Specify Specify: African-American 3 ♥ Widowed 4 □ Divorced Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) 11th Honemaker Damestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Wilbert Brown Loretta Fletcher 19a. Informant's Name/Relationship (Type, Print) Deborah Redman/ Daughter Page 1 and 2 12 J Kings Crossing Court, Cockeysville, MD 21030 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 N Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) King Memorial Park 1-21-10 Woodlawn, MD ture of Funeral Service Licensee 22. Name and Address of Facility W1e Pineral Home P.A. of 39 to. Co. 9200 Liberty Road, Randallstown, MD 21133 23a. Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition resulting in death) SEPSIS Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): the attending physician and hed for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ___ detached for in the past 12 months?
1 Yes 2 X No Pregnant at time of death Day Year 1 ☐ Yes ∠ Z 9 ☐ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? pleted filled in by the funeral director, page 2 should 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has the Hospital or Attending Physician; The 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 🗌 Yes 2**X** No Other: ည 1 Inpatient 2 ER/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6X Other (Specify) HOSPICE 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 Pending work? 1 🗌 Yes Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, Statel Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

REDMAN

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29b. Signature and title of certifier

JENNIFER HAUF

32. Registrar's Signature Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2300 DULANEY VALLEY RD.

3 K Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29d. Date signed (Month, Day, Year)

TIMONIUM, MD 21093

2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 2010 Nancy Laws Reifsnyder JANUCLY /Medical c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Deat Examiner atonsvi timore rwot If Under 1 Year | If Under 24 Hrs. Hours | Min. Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, 6. Sex 7. Age (In vrs. last birthday) **Funeral** Year) 1 □ M 2 🗓 F 579-30-0766 Dec.21. Washington D.C. Director 88 1921 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a State 10h County 28a-f show ed other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at MD Baltimore Catonsville 1 ☐ Yes 2 ☑ No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number death with 709 Maiden Choice Lane 21228 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☒ No 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after of the setter and Mental Hygiene. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: If Yes, Give Year or Dates: Specify: White þ 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 7 is marked other than traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Congressional Staffer U.S. Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bolitha J. Laws Nancy Macleod မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) ortant: If item 27 is injury or other tra 47 Gerrish Lane; New Canaan, CT06840 Jeremy E. Reifsnyder Stepson 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State Department o Important: If i any injury or once. Atlantic Crematory 1/19/2010 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Funeral Home of Catonsville, Inc. Ashton Schwab Witzke 41 11015 -3 1630 Edmondson Avenue: Catonsville Approximate
Interval Between
Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final hysician disease or condition resulting in death) **ledical** Due to (or as a consequence of) _xaminer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificate has b autopsy performe 2 -100 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 LINO 1 Inpatient 2 ER/Outpatient 3 DOA this Certification: To After thi funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation Injury 1 Natural thin 24 hours after death.

the Funeral Director: After the function by the function of the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🕒 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. within 24 29d. Date signed (Month, Day, Year) 29b. Signature, and title of certifier 29c. License number

State Registrar

31. Date filed (Month, Day, Year)

30. In the and address of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland / Department of Health and Mental Hygiene Per me, 2902,04/06/2010dhb Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Daniel Francis Radice, Jr. 13, 2010 8:49PM /Medical <u>January</u> 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Atlantic General Hospital Berlin Worcester 6. Sex 1**X** M 2□ F Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 69 Yrs. 212-38-2850 Director September 19,1940Washington, D.C. Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the "marcal Eventina" aust be natified at aging. 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 No Delaware Sussex Selbyville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 31322 Founders Avenue Funeral 19975 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Black, White, etc. Armed Forces?
1 ☐ Yes 2 📉 No
If Yes, Give
Year or Dates; 1 ☐ Never Married 2X Married 21215-0036 1 ☐ Yes 2X No Specify. ð Specify. 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Caterer Restaurant Baltimore. Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Daniel Francis Radice, Sr. Laura Katherine Taylor 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Sari Beth Radice/ Wife</u> 31322 Founders Avenue Selbyville, Delaware 19975 20b. Place of Disposition (Name of cemetery, crematory or other place)
Montgomery
Crematorium Inc. 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State January 19, 2010 4 □ Donation 5 □ Other (Specify) Bethesda, Maryland 22. Name and Address of FacilityRobert A. Pumphrey Funeral Home/ ethesda-Chevy Chase. Inc. 7557 Wisconsin Avenue 21. Signature of Fufferal Service Licensee Bethesda-Chevy Chase, Inc. 75 Bethesda, Maryland 20814-3501 M00335 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Probable Anaphylaxis **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) attending physician and for use as the burial-tran CERTIFICATION APPROVED BY MEDICAL EXAMINER Due to (or as a consequence of) 13/10 701 Box 68760 Hospital or Attending Physician: The law requires that the death certificate be Physician/Medical If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No by the 9.9 P.0 9 Unknown 9 Unknown signed be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 M Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? has autopsy certificate performe 2 No 1 ☐ Yes 1 ☐Yes 2 ☐No r this certifica Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury Fo(Month Day, Year) 01/13/2010 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Found: Natural 2 Accident 5 ☐ Pending investigation Probable anaphylactic reaction to unknown substance 1 ☐ Yes 2X No Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Found: Home 28f. Location (Street and Number of Rural Route Number, City, or Town, State) Found: 31322 Founders Avenue, Selbyville, DE 4 Homicide within 24 hours aft

To the Funeral Di

completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1166 2MORT74 egistrar's Signature OROTHY

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State Registrar 31. Date filed (Month, Day, Year)

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Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 00981 State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JANUARY ELIZABETH M. SWANNER 2010 78, 2:35 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death GILCHRIST CENTER TOWSON BALTIMORE Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🗓 F Months Days Hours Min. 5/27/1921 Director 202-01-7862 Yrs. MARYLAND Usual Residence of Decedent 10a. State Director 10c. City, Town or Location 10d. Inside City Limits i item 27 is marked other than "natural", or items 23a or 28a-f s other traumatic event, the Medical Examiner must be notified MD BALTIMORE TOWSON 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 1632 MUSSULA ROAD 21286 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married ☐ Yes 2 🎇 No If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. 3 X Widowed 4 Divorced WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) BALTO. CO. PUBLIC 2121 d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) EXECUTIVE SECRETARY SCHOOL SYSTEM 12th GRADE Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 GILBERT PANUSKA ELIZABETH LAUTERBACH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) GREGG SWANNER/SON 1634 MUSSULA RD. TOWSON. 21286 MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Page 1 Department of Important: If it any injury or o ō 1X Burial 2 ☐ Cremation 3 ☐ Removal from State PARKWOOD CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) 1/20/2010 BALTIMORE, MD Signature of Funeral Service Licensee 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, 8521 LOCH RAVEN BLVD. TOWSON, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final remen Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months?

1 Yes 2 No Day Pregnant at time of death Month Year 9 Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by of Vital Records, 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Jas perform 1 🗌 Yes No Yes 25. Was case referred to medical a 26. Place of Death (Check only one) Hospital: 2 No Other: မ 1 Yes 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence Ma within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral of 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of of De Natural 28c. Injury at work? 28d. Describe how injury occurred injury 5 Pending 2 Accident 3 Suicide Investigation 1 ☐ Yes 2 ☐ No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the only one) best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) B 0~80m, MO 21204 701 N (MD) 32. Registrar's Signatur State

Registrar

Swanner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year plana Stephens 0452 AM Medical 2010 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death University Baltimore of Maryland Medical Center 5. Social Security Numbe If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthdav) 8. Date of Birth Birthplace (State or Foreign Country) 1 🕱 M 2 🗆 F Months Days Hours Min 46 Director 215-74-4547 0 - 7 - 1963MD Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location death with the Maryland Director 10d. Inside City Limits Examiner must be notified MD 1 Yes 2 No Rosedale Balto 23a or 2 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2201 Crossett Road 21237 SA items 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. than "natural", or þ 1 Never Married 2 Married 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: 3 Widowed 4 Divorced Specify Completed traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired permit. Page 1 and 2 should be filed within . Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the M any injury or other traumatic event, the Monoiee. Elementary/Seconday (0-12) College (1-4 or 5+) Good Samaritan Emergency Technician 12th grade Hospital Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harold Lee Stephens, Sr Anna Jackson 19a. Informant's Name/Relationship (Type, Print) Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tanya Y. Bellamy-Stephens 2201 Crossett Road Rosedale, MD 21237 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔀 Burial 2 □ Cremation 3 □ Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Arbutus Memorial 1-18-2010 Arbutus, 21. Signature of Fundral Service Licensee 22. Name and Address of Facility March East F/H 1101 E. North Avenue Balto, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Due to (or as a consequente of): hemorr hag Medical resulting in death) Examiner 1 week umonia Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of): Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has page 2 autons performed? 1 Yes 2 No funeral director, 25. Was case referred to medical B 26. Place of Death (Check only one) examiner?
1 Yes 2 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at within 24 hours after death.

To the Funeral Director: After 28d. Describe how injury occurred 1 Natural 5 \square Pending Accident 1 Yes 2 No Investigation Could not be filled in by the 3 Suicide Place of Injury - At home, farm, street, factory, office bullding, etc. (Specify) determined 28f. Location (Street and Number or Rural Route Number City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) Jan 2010

Registrar
DHMH 17 Rev 7/2009

State

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S. Greene St. Baltimore

MD

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

JAN 20 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene T - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 2-0 10 **Physician** -107 M Dorothy M. Schuman January /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 1em 1.5hrn Baltimore Washington Medical Center G If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs, last birthday) Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** 1 □ M 2**K** F Months Days Hours Min. 87 216 12 3072 Director Maryland 06/10/1922 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show in than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at 1 Yes 2 No Director N/A Maryland **Baltimore** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with 1013 Church Street 21225 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ▼ No 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 🛣 If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2X No Specify: þ Specify: 3 X Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygienn Important: If item 27 is marked other the any Injury or other traumatic event, the once. Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Ward (not available) ဥ Anna 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Warren Lee Schuman Jr. / son 302 Winsome Drive Hampstead, Maryland 21074 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Bayview Crematory 01/14/2010 | Baltimore, Maryland 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licensee monuseus 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Int. Enter the disease, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed end the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, signed by the attending physician Physician/Medical detached for use as 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed has been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an To the Hospital or with within 24 hours after death.

To the Funeral Director: After this certificate has completely filled in by the funeral director, page? 1 □Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Department Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 4 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier rtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29b. Signature an nd title of centifier 29d. Dale signed (Month, Day, Year)

HV

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State Registr<u>ar</u> 31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

r's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type

Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland / Department of Healthyand Mantal Hygiene Certificate of Death Reg. No. For State Registra 00984 Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 2010 9:35 A M Robert Spencer Safrit January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 454 Ruby Drive Aberdeen Harford If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 M 2 □ F 213-36-8598 Director Aug 10, 1938 North Carolina Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show Director 1 ☐Yes 2√ No Aberdeen MD Harford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21001 Funeral 454 Ruby Drive 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian 72 hours after 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: white 2 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 h and Mental Hygiene. 7 Is marked other than "r College (1-4or 5+) transportation truck driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked oth any Injury or other traumatic event Be Edith Virginia Wilhelm Edward Charles Safrit 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 454 Ruby Drive Aberdeen, MD 21001 Jean A, Safrit/spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Servi ²² Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 23a. Part 1. Enter the disease or complications to shock, or heart failure. List only one cause Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cau (Final disease or condition resulting in death) **Physician** CHH Lell Conuma /Medical Que to (or as a consequence of) Examiner なない Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last PROVED BY MEDIC Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) Box 68760 physician CERTIFICATI Physician/Medical the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) P.0. 9 Unknown 9 Unknown ģ signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy certificate perform of Vital 2 4K 1 □ Yes director 25. Was case referred to medical 26. Place of Death (Check only one) caminer' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 XYes 21 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ٩ 28a. Date of Injury (Month, Day, Year) 27. Many of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred Division Hospital or Attending tural 5 Pending investigation Injury death. 2 Accident 09/22/2009 Unknown M 1 ☐Yes 2 XNo nours after death.

neral Director: #

filled in by the for Subject fell 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 454 Ruby Drive Place of Injustice Special Home 4 ☐ Homicide Aberdeen, MD 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier completely (Check only one) within 2 To the F 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 116 M. ()-2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

31. Date filed (Month, Day, Year

JAN 20

4106

32. Registrar's Signature

Amend 20a-Please Type or Brintin Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month January Betty Smith 2010 8:10 PM M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Suburban Hospital Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number unk 6. Sex 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Year) 1921 1 □ M 2 🔽 F Sept 23 South Carolina Director 88 Usual Residence of Decedent 28a-f shov 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits Director notified 1 Yes 2x No MD Montgomery Bethesda 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? the Medical Examiner must be items 23a Funeral 5721 Grosvenor Lane 20814 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. "natural", or Completed by 1 Never Married 2 Married Baltimore, Maryland 21/215-0036 1 ☐ Yes 2 🔀 No Specify: black 3 ♥ Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) child care permit. Page 1 and 2 should be filed wit. Department of Health and Mental Hygier Important: If item 27 is marked other tany injury or other traumatic event, the once. caretaker unk unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Toni Wright/niece 9013 Congress Place Landover, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 📉 O state Ardent Cremations 1/10/2010 Hanover, MD Signatur of Funeral Ser Roman 22 Name and Address of Facility Ardent Cremations Svcs. /522 Cornelley State Anatomy Board 655 W. Baltimore Street Dr. 21076 21201 Ste. N Hanover, MD MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Ph sician/ hermonia disease or condition Medical resulting in death) Examiner CHON Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a nsequence of): 21/0 X10 that the death certificate be executed physician and the burial-trans Due to (or as a consequence of) resulting in death) Last the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No for Month Day 5 Other (specify) detached 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed 23e. Did tobacco use contribute to the cause of death? ģ extension. pe To the Hospital or Attending Physician: The law requires i within 24 hours after death.

To the Funeral Director: After this certificate has been sign 2 No 1 Yes 3 Probably 4 Unknown Completed page 2 should enver 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, 2 No ပ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1. Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation ☐ Accident the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 9 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 3 Cen Hing Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and e of 29d. Date signed (Month, 2010. 30. Name and address who completed cause of death (Item 23a) (Type, Print) KUUWITE, 20852 4200 State JAN 20 201 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 00986 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year Albert Stone Tanuary 2010 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death of Himore Baltimore Hospital 5. Social Security Number unk If Under 24 Hrs 7. Age (In vrs. last birthday Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth 1 🕅 M 2 🗆 F Months Min Aug 27, Year) 926 83 Yrs Director Usual Residence of Decedent 28a-f shov 10a. State 10b County 10c. City, Town or Location injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 □ No Baltimore MD 10e, Street and Number 10f. Zip Code items 23a or 10g. Citizen of What Country? Funeral USA 21215 3901 Garrison Blvd 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc unk permit. Page 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examit once. þ 1 Never Married 2 Married 1 Yes 2 No Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2X No Specify: black Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation unk unk 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) unk unk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk unk 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21215 2401 W. Belvedere Avenue Baltimore, MD Sinai Hospital of Baltimore Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 🖫 Sther (Specify) in State State Anatomy Board 655 W. Baltimore Street Baltimore, MD Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. For heart failure. List only one cause on each line. 23a. Part shock. Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) **Examiner** years Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or iinjury that initiated events or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ signed by the atter in the past 12 months? Day Year Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performe certificate 1 Yes 2 No __ Yes 2 No 25. Was case referred to medical funeral director, To Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ No Other: ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, Inpatient 2 🗆 After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? Certificate: 28b. Time of 28d. Describe how injury occurred Natural 5 Pending injury 1 🗌 Yes 2 🗌 No Accident Investigation filled in by the 24 hours after deal Funeral Director: Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier сотріете (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Shuad Month riy 10:45 A^M Medical 2010 January 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 6420 Empty Song Road Columbia Howard Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Ukraine **Funeral** 8. Date of Birth 1 □**M**M 2 □ F Months Davs Hours Min. NOV 5, 1960 Director 217-43-9476 49 Usual Residence of Decedent or 28a-f show 10b. County the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Medical Examiner must by Funeral 21044 6420 Empty Song Road United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? ģ 1 Never Married 2 Married Maryland 21215-0036 If Yes Give 1 ☐ Yes 2 ☐xNo Specify: 3 Widowed 4 Divorced Specify: White Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Software Programmer Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Feliks Yakovlevich Shvadskiy Margarita Ivanovna Bykova 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tatyana Ivanovna Tertitsa/wife 6420 Empty Song Road Columbia, Maryland 21044 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐xcremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crematory 1/16/2010 Woodbine, Maryland e of Funeral Service License 21. Sign ^{22. Name and Address of Facility}
Going Home Cremation Service P.O. Box 784
Beverly L. Heckrotte, P.A. Clarksville, MD 21029 M00957 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician. Rectal Cancer disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed for use as the burial-trans Cause (Disease or imiury that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death cate has been signed by the a page 2 should be detached 9 Unknown bed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has autopsy death? 1 ☐ Yes 2 ☐ No 1 Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5X Residence 6 Other (Specify 2 X No မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28h Time of 28c. Injury at hours after death. 28d. Describe how injury occurred X Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation completed filled in by the Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital within 24 hours a Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, it may open out the cause of the cause 29b. Signature and fittle 29d, Date signed (Month, Day, Year) MD D0058779 January 15, 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5450 Knoll North Drive Suite 140, Columbia, Maryland 21045 M.D. Karl Kasamon, 31. Date filed (Month) Registrar's Signatur State Registrar

DHMH 17 Rev 7/2009

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		•	For State Of Maryland / E State Registrar		tificate of E			g. No. 2010	00988		
	Physicia Medic		1. Decedent's Name (First, Middle, Last) Roslyn Spitzer		2. Date of Death Month January	17, 2010	3. Time of Death 8:58 A ^M				
	Examin	er	4a. Facility Name (if not institution, give street and number) Landow House	Location of Death		4c. County of Dea					
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birt	т Г	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	9. Bir Year) Co	thplace (State or Foreign		
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	r death or item niner n	by Fur	11. Marital Status 1 □ Never Married 2 □ Married 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No	13. W	as Decedent of Hi Yes, specify Cuba	spanic Origin? (Spen n, Mexican, Puerto I	cify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit			
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	0 = 6 T		Arthur B. Spitzer/son 1	1 Ox	ford Str		vy Chase	e, Marylan	d 20815		
Baltimore,	age 1 and ent of Hea nt: If item ry or other		1 Puriol 2 Promotion 3 Permoval from State cemeter	ery, crema	ition <i>(Name of</i> atory or other place ney Crem	atory 1/1		20c. Location - City or Woodbine	Town, State Maryland		
Balti	permit. Page 1 a Department of H Important: If ite any injury or ot once.		21. Signature of Funeral Service Licensee M00957	22. GC B€	Name and Address oing Home everly L.	s of Facility Crematic Heckrott	n Service, P.A.	ce P.O. B Clarksvil	ox 784 le, MD 21029		
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Box 68760	ath certificate be executed attending physician and for use as the burial-transit	n/Me	IF FEMALE: 23b. Was decedent pregnant in the post 12 months? 23c. If yes, outcome of pregnancy 1 □ Live Birth 2 □ Fetal death	ь »П	Estania pregnana	.,		23d. Date of de	elivery		
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_	To the Hospital or Attending Physician: The law requires that the death certificate is within 24 hours after death. Within 24 hours after death. The Funeral Director: After this certificate has been signed by the attending physic completed filled in by the funeral director, page 2 should be detached for use as the knowledge of the completed filled in by the funeral director, page 2 should be detached for use as the knowledge.	Medical	29a. Certifier (Check conly one) 1 Certifying Physician: To the best of my knowledge, 2 Medical Examiner: On the basis of examination and/conly one) 3 Certifying Nurse Practioner: To the best of my know	or investi	gation, in my opinic	n, death occurred at	the time, date and	place, and due to the	cause(s) and manner stated.		
	Vithi Vithi Cong		29b. Signature and title of certifier Ming Fit Le		29c, License			Od. Date signed (Mont			
	15V		30. Name and address of person who completed cause of death (Item 23a) ((Type, Pr	int)	R+	Dark.	11. (120)	2850		
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			23a. Part 1. Enter the disease, or complicate shock, or heart failure. List only one of	tions that caused the death.	. Do not enter the mode of dyin	ng, such as cardia	c or respiratory a	rrest,	Approximate Interval Between Onset and Death
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,09	icate be executed physician and s the burial-transit	_	resulting in death) Last	Due to (or as a conseque	ence of):				
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			30. Name and address of person who comp	, -		-011	10	0111112	210
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	Funeral Director		5. Social Security Number 212–30–2441	6. Sex 1 X M 2 □ F	7. Age (In yrs. I.	as <i>t birthd</i> ay) Yrs.	If Under 1 Months	Year Days	If Under: Hours	Min.	8. Date of Bir (Month, Da 12/18/	th ly, Year) 193	9.	Birthpl Count	ace (State or Foreign try) unk		
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036	be filed within 72 hours after death with the Maryland that Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 🛣 Mar 3 □ Widowed 4 □ Divorced	12. Was Dece Armed For 1 \(\text{Yes} \) Giv	12. Was Decedent Ever in U.S. 13. V Armed Forces? 1 □ Yes 2 K No		Was Decedent of Hispanic Origin? (Spec If Yes, specity Cuban, Mexican, Puerto R 1 □Yes 2 X No Specity:						ce - American Indian, ck, White, etc. y: White				
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212	filed within I Hygiene. other than "ent, In Me	Com	Elementary/Secondary (0-12)	4	-401 3+)	Mach	inist		40 Math	-da Mana	(First, Middle	Mf					
/land	2 should be filed and Mental Hygi is marked other aumatic event, II	To Be	17. Father's Name (First, Middle, Oscar Schnauf	•					Marc	garet	Jones						
Mary	S a S	13	19a. Informant's Name/Relations						ng Address (Street and Number or Rural Route Number Legacy Cr., Charlotte, N								
Baltimore, Maryland	ages 1 and 2 nt of Health t: If Item 27 i	C 8	Cindy A. Dula 20a. Method of Disposition 1 □ Burial 2 【X Cremation	3 ☐ Removal from S	State 20b. P	lace of Dispo emetery, crei	sition (Name natory or oth	e of er place	9)	D	/2010	20c. L	ocation - Cit				
Baltin	permit. Pages 1 and Department of Heal Important: if item 2 any injury or other once.		4 □ Donation 5 □ Other (3		Da		2. Name and	Addres	s of Facilit	y Hu	bbard 1	Fune	ral Ho	ome,	Maryland Inc. and 21229		
	Physician Medical Examiner bulkasician and buksician and sthe brutal-transit	edical Examiner	23a. Part 1. Enter the disease, o shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, it as it, it as it, it is the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (ach line. to stol or as a consequ	uence of):	Brai		Car				<u>— [4]</u>		Interval Between Onset and Death		
O. Box (ath certif	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Live b	come of pregna birth 2 ☐ Feta nant at time of d own	Ideath 3	☐ Ectopic pre☐ Other (spe		/				23d. Date of Month		ery Day Year		
ls, P.	res that the de signed by the a be detached to	þ	Part II. Other significant condit	· ·	_	-								ute to th	ne cause of death?		
of Vital Records,	The law requir ate has been s page 2 should	Completed	CHIOME				7				24a. Was	s an opsy ormed?	24b. We	or to co ath?	psy findings available mpletion of cause of		
Vita	ysician: The lis certificate hidirector, page	Be	25. Was case referred to medical examiner?	Hospital:				Othe	ar.		(Check only						
	ding h. After fune	ation: To	1 Inpatient 2 En/Outpatient 3 DUA And Nursing Home 5 Hesidence 6 Other (Specify)									y)					
Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune.	Certification:	3 ☐ Suicide 6 ☐ Could	_: Zoe. Flace	of Injury - At ho ng, etc. (Specif	ome, farm, st	reet, factory,	office			28f. Location City or To			or Rura	I Route Number,		
	To the Hospital within 24 hours a To the Funeral C completely filled	Medical (29a. Certifier (Check only one) 1 Certify 2 Medica	ing Physician: To the i Examiner: On the b and man	best of my kno asis of examina ner stated.	wledge, dea tion and/or i	th occurred anvestigation,	at the tir in my o	ne, date a pinion, de	nd place, ath occur	and due to the red at the time	e cause e, date a	(s) and mani nd place, an	ner as s d due to	stated. the cause(s)		
	To th withir To th comp	Me	29b. Signature and title of certifi	Dw	2 M	D			e number	96			nate signed (
			30. Name and address of person K. Ambalau	who completed cause	se of death (Item	123a) (Type	Print)	20 a	0 0	nlen	Burn	ie,	MD	2	8 th 2010		

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Zolo 29 PM MOLLIE SETREN Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death SPRINGHOUSE ASSISTED LIVING BALTIMORE PIKESVILLE . Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) 1 🗆 M 2 💢 F Hours 2/67 1921 Director 217-18-1463 88 Yrs MD Usual Residence of Decedent nit. Page 1 and 2 should be filed within 72 hours after death with the Maryland nartment of Health and Mental Hygiene. ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits MD BALTIMORE N/A 1 X Yes 2 □ No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3041 FALLSTAFF ROAD, #303 21209 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 Never Married 2 Married Black, White, etc. 1 Yes
If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 X Widowed 4 Divorced Completed Specify: WHITE Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ PHILIP SIMON BECKY F SPIZLER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or other trau ED SETREN / SON 828 SLATERS LANE, #206, ALEXANDRIA, VA 22314 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) HEBREW YOUNG MEN 1/19/2010 WOODLAWN, MD 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Enysician/ Due to (or as a consequence of) DEMENTU disease or condition Medical resulting in death) Examiner TRIAL Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of, attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate bewithin 24 hours after death.

Within 24 hours after death.

To the Funeral Director after this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the brun. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year 2 No 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a, Was an autopsy performed? Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 M Other (Specify) 1 🗆 Yes 2 No ျ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 □ Yes 2 □ No 28b. Time of 28d. Describe how injury occurred 1 Matural 5 Pending Investigation 6 Could not be Accident Suicide 3 ☐ Sulciue 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

20

35

32. Registrar's Signature

Baltimore MD 21209

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ JANUARY 15° DANIEL 2010 SCHAPIRO 1:55 Рм Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death GILCHRIST HOSPICE CARE TOWSON BALTIMORE 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthdav Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth 1 X M 2 🗆 F Days Hours Director Yrs 0570871913 213-09-5009 96 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 X No MD BALTIMORE PIKESVILLE 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 6 BRANCHWOOD COURT 21208 USA permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene.

Important; If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner m. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. ò 1 Never Married 2 Married 1 ☐ Yes 2 💢 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. 3 X Widowed 4 ☐ Divorced Completed Specify: WHITE Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) EXECUTIVE TEXTILE RECYCLING Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ SOLOMON SCHAPIRO BERTHA K KRESS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BENJAMIN S. SCHAPIRO / SON 54 WOODWARD LANE, LUTHERVILLE, MD 21093 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State X Burial 2 ☐ Cremation 3 ☐ Removal from State ☐ Donation 5 ☐ Other (Specify) BETH TFILOH CONG. 1/18/2010 WOODLAWN, MD Signature of Funeral Service Licens 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1. Enter the disease Interval Between Onset and Death Immediate Cause (Final Ph sician/ ewal Effusion disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner TV Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events been signed by the attending physician and should be detached for use as the burial-trar Due to (or as a consequence of) resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months? Pregnant at time of death Month Dav Year 2 No 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛱 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an after death.

Director; After this certificate has performed?

Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospita 2 No Other: မြ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a

To the Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier CRNP 12149194 January 15, 2010 1000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N. Charles 701 Gran arian Towson, MD 21204

DHMH 17 Rev 7/2009

State Registrar

32. Registrar's

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Nhu Bich Tran January 2010 34 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore 8 Montrose Avenue Owings Mills 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2XX F Months Days Hours Min (Month, Pay, Yea Vietnam 217-37-3157 75 Yrs. Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County items 23a or 28a-f sho her must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 ☐ Yes 🏋 No Maryland Baltimore Owings Mills 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral Vietnam 8 Montrose Avenue 21117 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Armed Forces? Black, White, etc. ö ģ 1 Never Married 2 MMarried 1 Yes 2 No Specify: If Yes, Give Year or Dates "natural", Specify: Asian Completed 3 Widowed 4 Divorced al Hygiene. d other than "natural event, the Medical E 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Homemaker Own Home event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F is marked of ၉ Nhiep Tran Sa Ton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health a Important: If item 27 is any injury or other tra Anthony Ton (Son) 22208 Overview Lane, Boyds, Maryland 20841 Date 21, 20b. Place of Disposition (Name of cemetery, crematory or other place) Park Lawn Memorial Park & Menorah Grdns 20a. Method of Disposition 20c. Location - City or Town, State XX Burial 2 Cremation 3 Removal from State 4 Donation 5 other (Specify) Jan. 2010 Rockville, Maryland Signature of Further Service License 22 Name and Address of Facility Eckhardt Funeral Chapel, P.A. 11605 Reisterstown Road, Owings Mills, MD 21117 Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest slock, or heart failure. List only one cause on each line. Interval Between Onset and Death ediate Cause (Final Physician/ CANVICA Cancen disease or condition month Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): death certificate be executed and resulting in death) Last Due to (or as a consequence of): physician a sthe burial-1 Physician/Medical attending p IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 - Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Year Pregnant at time of death 5 Other (specify) signed by the a a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u></u> 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate Yes 2 N 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 2 No Other: ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA this 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 1 Watural 28a. Date of injury (Month, Day, Year) 28b. Time of After t 28c. Injury at Certificate: 28d. Describe how injury occurred the Hospital or Attending 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation neral Director: / 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined after City or Town, State) within 24 hours a

To the Funeral C

completed filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signat 29c. License number 29d. Date signed (Month. Day, Year)

State Registrar

DHMH 17 Rev 7/2009

Maryland 21215-0036

Baltimore.

Box 68760

Records,

Vital

Division of

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

rolp M

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BAUT

Please Type or Brint in Black Indelible Ink Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 00994 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav Year **Physician** Aubrey W. Tate 10:00 PM January 8, 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Takoma Park, MD IMO

If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Monato Day, Year)

Hours Min. 8. Date of Birth
(Monato Day, Year) Sligo Creek Nursing Home Montgomery 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🖫 F 94 577-26-9827 Yrs Director 08/15/1915 Washington, Usual Residence of Decedent the Maryland 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at 1X Yes 2 □ No Director DC Washington, DC 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Items 23a or 6401 2nd Place N. W, 20012 death USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ XNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 ö 1 ☐ Yes 2 X No Specify: \$ Specify 3 XWidowed 4 ☐ Divorced "natural". **Black** Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ges 1 and 2 should be filed within t of Health and Mental Hygiene. If itam 27 is marked othar than Elementary/Secondary (0-12) College (1-4or 5+) 12th Federal Government <u>Statistician</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Henry Johnson Scott 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
6401 2nd Place, NW
Washington, DC 20012 19a. Informant's Name/Relationship (Type, Print) Dolores W. Morris/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Importent: If ita any injury or ott 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 1/25/10 ' 4 ☐ Donation 5 ☐ Other (Specify) Arlington Nat Cem Arlington, VA of Funeral Service Licenses 22. Name and Address of Facility Austin Royster Funeral Home M00996 3821 14th Street, NW, Washington, DC 20011 23a. Part1. Emer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician Cut /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in tilated events resulting in death) Last Examiner Due to (or as a consequence of): physician and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physiclan/Medical as IF FEMALE esn 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No ģ Day 4 Pregnant at time of death 5 Other (specify) P.O. the detached 9 Unknown igant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, by pe VW. OK 2 E No 3 Probably 4 □Unknown 1 Tes Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has page 2 autopsy performed certificate 2 No Division of Vital 1 🗌 Yes 2 No 1 Tes the Hospital or Attanding Physicien: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 10 1 🗌 Yes 12 3 No 3∏ DOA this 28c. Injury at Work? 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: After Injury 1 Natural 5 Pending death. 1 Tyes 2 No 2 Accident investigation after death | Diractor: / d in by the f 6 Could not be determined 3 Suicide 28 e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours aft To tha Funaral Di completely filled in 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, 211 30. Name and address of person who co of death (Item 23a) (Type, Print) 2

State

Registrar

JAN 20 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 00995 State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Ella Thoms Month 18 2010 January /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner OWN VENOT romit If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | (Month, Day, 9. Birthplace (State or Foreign Country)
Maryland Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days Year. 1 □ M 2 🔀 F 99 1910 Director Aug. 13, 220-07-1713 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must he maritimal and injury or other traumatic event, the Medical Examinar must he maritimal and injury or other traumatic event, the Medical Examinar must he maritimal and injury or other traumatic event, the Medical Examinar must he maritimal and injury or other traumatic event, the Medical Examinar must he maritimal and injury or other traumatic event, the Medical Examinar must he maritimal and injury or other traumatic events. 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 Yes 2 No Directo MD Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 709 Maiden Choice Lane 226S 21228 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify Specify: White þ 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Elizabeth Dasch Anthony Dasch ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marie Tabor Daughter 707 Maiden Choice Lane 3102; Catonsville, MD 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Durial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Other (Specify) Sacred Heart of Jesus 1/20/2010 Baltimore, MD 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Sign the of Paneral Service 1630 Edmondson Avenue; Catonsville, MD 21228 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death Immediate Cause (Final Physician 6 MG disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Und riying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 attending physician Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 2 1 HO Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? Yes 2 100 certificate 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: Tursing Home 5 Residence 6 Other (Specify) Hospital: 1 Tes 2 LN Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death e Funeral Director: 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🕒 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated within 2.

State Registrar

29b. Signature and title

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

711 gistrar's Signature

tone

DHMH 17 Rev 1/2001

Maiden

29c. License number

hoice Lane Ba

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 00996 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician Year 11:37 AM Frederick Gustav Timmel JAN 18 2010 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St AGNES HOSPITAL BALTIMORE 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 1 M 2 □ F **Director** 398-28-1843 85 Nov. 19, 1924 Wisconsin Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show ir than "natural", or items 23a or 28a-f shore the Wedical Examiner must be notified at Director 1 ☐ Yes 21 No MD Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 707 Maiden Choice Lane Art 7101 by Funeral 21228 USA filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 X Married 1 ☐Yes 2 ☐ If Yes, Give Year or Dates: Specify: White 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, Italia Electrical Engineer Defense/Military Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be Walter Gustav Timmel Sadie Josephine Bogle 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catonsville, MD Marjorie Timmel Wife 707 Maiden Choice Lane Apt 7101 21228 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ganrison Forest 1/28/2010 Owings Mills, MD 21. Signature of Funeral Service Licensee 22. Name and Address of FacilitySterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catorisville, Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. It only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ANOXIC ENCEPHALOPATHY DAY5 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) and burial-trar Due to (or as a consequence of): physician the burial Physician/Medical IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy P in the past 12 months? Year Day 4 Pregnant at time of death 5 ☐ Other (specify) □Yes 2 No the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ pe CARDIAL ARREST 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed PARKINSON'S DISEASE DEMENTIA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 1 □Yes 2 No 2 🗆 No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 2 ☐ ER/Outpatient 3 ☐ DOA this s after death.
I Director: After this of in by the funeral d 27. Manner of Death 28a. Date of Injury (Month, Day, Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 □Yes 2 □ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral D 1 Lertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier cal (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

EDERICK

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Division of Vital Records.

JAN 20 2010

31. Date filed (Month, Day, Year) ----

M.D

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



P23748

JAN, 18, 2010

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician 2010 Irene J. Tuma January 8:05 РМ /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Wilson Health Care Center Gaithersburg Montgomery 8. Date of Birth (Month, Day, 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** ^{Year)} 1920 Months Days Hours 1 □ M 2 🕅 F 389-12-7094 89 Wisconsin **Director** Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Modical Examinar must be retified an once. 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Director Maryland Montgomery Gaithersburg 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20877 401 Russell Avenue, #207 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1∐Yes 2XNo Specify. 2 White 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ George Fonk Josephine Reiter 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathleen Hopkins / Daughter 10904 Show Pony Place, Damascus, Maryland 20872 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State January 1 X Burial 2 ☐ Cremation 3 Removal from State St. Felix Cemetery 4 □ Donation 5 □ Other (Specify) 2010 Wabasha, Minnesota 21. Signature of Funeral pervice Licenses Robert A. Pumphrey Funeral Home/Rockville, Inc. M01305 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Diset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, it says a sure of the conditions cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Dunity for as a gunsaquency off Hospital or Attending Physiclan; The law requires that the death certificate be executed and as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, signed by the attending physician I be detached for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Be Completed by page 2 should be 2 No 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has within 24 hours after death.

To the Funeral Director: After this certificate I completely filled in by the funeral director, page 1∐Yes 2. Wi√o 25. Was case referred to medical examiner? 26. Place Death (Check only one. Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗆 No 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27, Manner of Death 1 Natural 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 04115 2010 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) H. Robert Birschbach, M.D. 201/Russell Avenue, Gaithersburg, Maryland 20877 31. Date filed (Month, Day_Year) 32 Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death Month **Physician** /Medical 2010 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner TIMURE VA COMMUNITY LIVING + REHABILITATION If Under 24 Hrs. 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 1 X M 2 □ F Days Hours Min. **Director** 216-12-8412 87 Maryland 07/13/1922 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or items 23a or 28a-f show event, the Medical Exactings must be notified at Director 1 XYes 2 ☐ No Baltimore MD N/A10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 2536 Edgecombe Circle N Apt.C 21215 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2X No. þ Specify Specify: Black 3 X Widowed 4 ☐ Divorced "natural", Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12th Grade Construction Operation BGE Department of Health and Mental Hygic Important: If Item 27 Is marked other any injury or other traumatic event, In once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ည Unknown Pauline White 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Annette Johnson (Daughter) 1027 Kevin Rd, Baltimore, MD 21229 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest 01/27/10 | Baltimore, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Joseph H. Brown Jr. Funeral Home elliano 2140 N. Fulton Ave., Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** MEN disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed thous after death.

Ye hours after death.

Funeral Director: After this certificate has been signed by the attending physician and stelly filled in Director: After this certificate has been signed by the attending physician areally filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕱 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 1 □ Yes 2 (X) No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ Mo Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours a To the Funeral D 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) au, JAN. 16, 2010

State Registrar 31. Date filed (Month, Day,

OCH

trar's Signature

BOULEVARD, BALTIMORE, MD 212/8

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 30AM Physician/ Month Year POID 201 M ſΥ Medical 4b. City, Two, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** ueen evens nne 9. Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth . Age (In yrs. last birthday) **Funeral** 1 - M 2XX Months Min. Hours (Month, Pay, Year) 10/13/16 93 Director 28-5746 Usual Residence of Decedent "natural", or items 23a or 28a-f show adical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County Director Stevesville MD 1 Yes 2 No Queen Anne 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21666 Completed by Funeral 232 Ackerman Road USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes ※※ No
If Yes, Give Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: Specify: XXWidowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Demma Jesse Ward Lester Neal Whiting 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
232 Ackerman Rd. Stevensville, MD 21666 William Whiting Jr. son Baltimore, 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Blue Ridge Mem. Gard 1-10-2010 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Beckley, WV 25801 4 Donation 5 A Other (Specify) . Signature of Function ervice Licensee 22. Name and Address of Facility Blue Ridge Funeral Home WV Box 1536 Beckley, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) CUA Medical Due to (or as a consequence of): Examiner Foh lla Sequentially list conditions. Examiner If any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Disease or linjury Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) cate has been signed by the a page 2 should be detached a 🗌 Unknown 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death? certificate ! 1 Yes 2 No 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 No မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending injury work? 1 X Natural 2 🗌 No Acciden Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of e 29c. License number 29d. Date signed (Month, Day, Year) 100 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar JEFFREY

31. Date filed (Month, Day, Year)

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32. Registrar's Signature